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the Canadian Nurse

VOLUME 57 • NUMBER 4
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APRIL 1961

HIGHLIGHTS

SCHIFFMANN — Neurological Evaluation of the Infant

HOLMAN — Erythroblastosis — The Nursing Viewpoint

DANTOW — The Preschool Years — Prevention of Disease

ANDERSON — Management of the Diabetic Child

COBURN — Adolescence

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Between Ourselves

A few months ago, the release of a new book by *MacLean's Magazine*, "Canada — the Portrait of a Country," gave us a fascinating overview of the flow of events and developments in our country during the past half century. Equally interesting, though written in less descriptive prose and accompanied by dozens of tabulations of pertinent data, is the annual *Canada Year Book*. We commend both of these volumes to your reading if you would be well-informed on virtually any aspect of Canadiana.

Much of the information included in Chapter VI of the Canada Year Book is of direct concern to us as nurses. For instance, on page 273 in that chapter is a small section on sick mariners:

> Under the authority of Part V of the Canada Shipping Act, the Department of National Health and Welfare provides prepaid health services for crew members of foreign-going ships arriving in Canada.

There is more to that section relating to coastal and interprovincial crew members but the quoted statement provides the background for a very interesting query that reached our office recently from a hospital that is called upon regularly to care for sick mariners. Their problem was one of communication. How can a nurse, even though she may be reasonably fluent in both English and French, how can she secure any essential information from a seriously ill patient who does not understand a single word of either of her languages?

This problem of multiple languages is certainly not limited to federal hospitals. Again, referring to Canada Year Book, we find that 31,643 Hungarians came to Canada in 1957, that in 1958 there were 27,043 Italians, that from 1946 to 1959, a total of 141,974 persons from the Netherlands, 87,167 from Poland, as well as a mixture of many other nationalities settled in our midst. Thousands of those people have been and are being your patients. How do you communicate!

The suggestion has been made that we might prepare a multi-language chart of many simple words and phrases that would assist any nurse in any hospital in Canada — perhaps anywhere in the world —to know how to ask such questions as: "What is your name? Where is the pain?" It will be a lengthy task but we are agreed here that it would be a very worthwhile contribution to good public relations.

If such a listing is prepared, what words or phrases would you like to be able to find in it? We have a fairly broad list now but we would welcome your additions. What languages should we concentrate on? Please let us have your ideas on this matter.

* * *

Being president of the largest Association of Registered Nurses in Canada is a very time-consuming business. As you read of all of the association activities **Ella Mae Howard** discusses in her editorial, it is easy to come to the conclusion that very special qualities of leadership are called for. Those qualities our guest editor has in abundance.

Though she was born in Ontario, Miss Howard received all of her preliminary education, including preparation as a school teacher, in Alberta. She had taught for a few years before entering the school of nursing of the Royal Alexandra Hospital, Edmonton. After graduating she engaged in general staff nursing for a while, then enrolled in the McGill School for Graduate Nurses taking teaching and supervision. While serving as an instructor at the Civic Hospital, Peterborough, Ont., the west called Miss Howard back. She occupied increasingly important positions on the prairies before accepting an appointment on the staff of the School of Nursing. University of Toronto. She is presently the director of nursing at New Mount Sinai Hospital, Toronto.

* * *

From birth through adolescence is a relatively short period in terms of years but it encompasses some of the most problematical years in the life of the average individual. In this issue, we have touched briefly on many facets of this period. We regret that space did not permit us to publish the complete article by **Dr. Wanda Schiffmann** in this number. You will find the second half in the May issue.

* * *

Acting on the suggestion of an eminent subscriber, we have listed five of the featured articles under "Highlights" on the front cover. How do you like the idea?

A smile is something of no value until it is given away, yet it cannot be bought, begged or stolen.

— *Vision*, Vol. 15, No. 1

in PRIMARY DYSMENORRHEA - METASPAS - DIHEXYVERINE G/O

NAME
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AGE
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CLINIC NO.

COMPLAINT - DURATION & SEVERITY

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NAUSEA WHEN VOMITING WHEN

PREVIOUS MEDICATION -

TREATMENT WITH METASPAS - DATE

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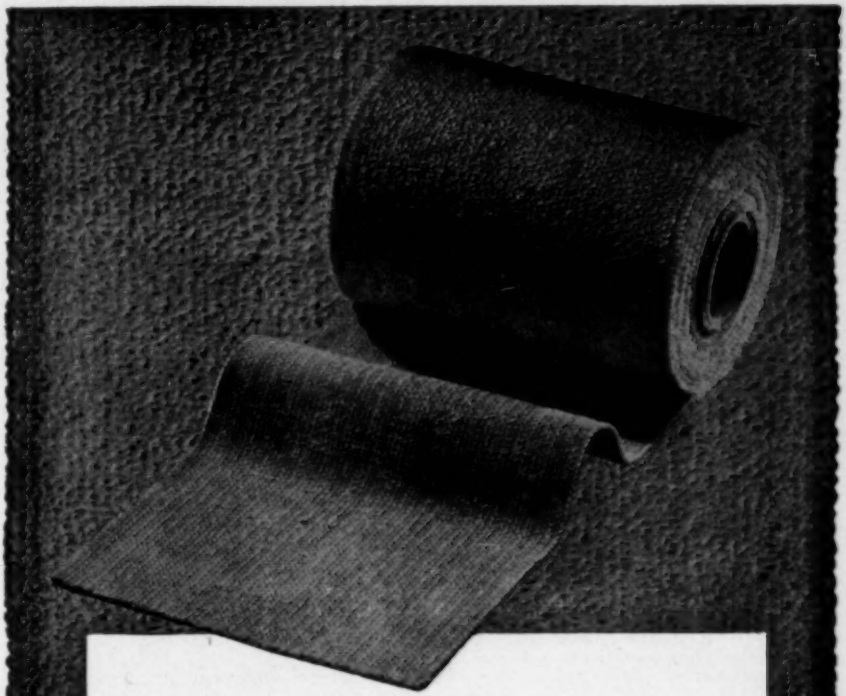

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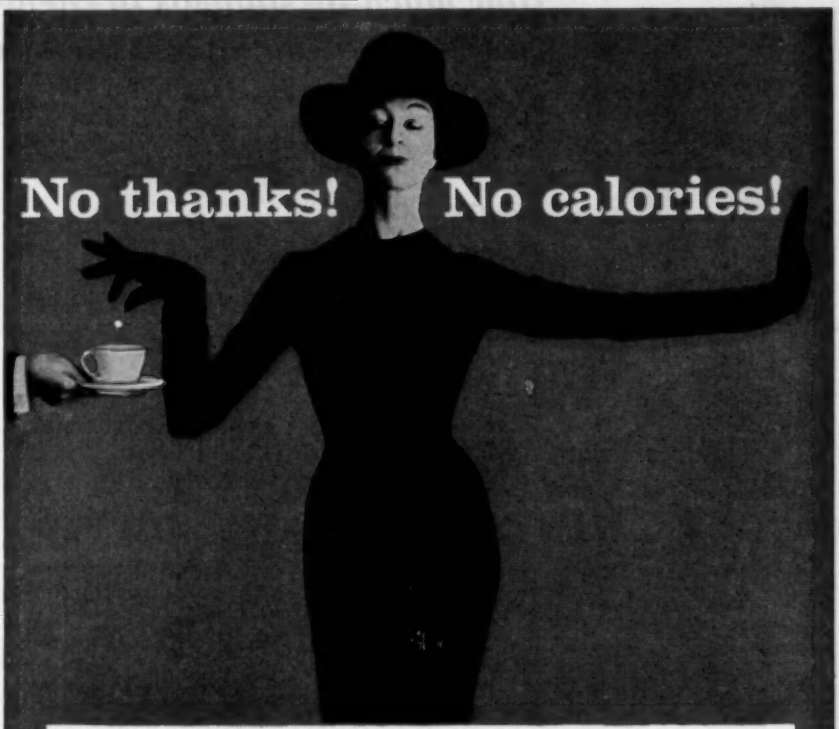

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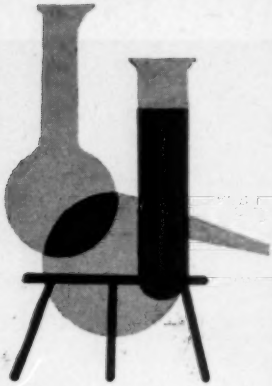

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By L. EARLE ARNOW, Ph.G., B.S., Ph.D., M.B., M.D., President, Warner-Lambert Research Institute, Morris Plains, N.J.; formerly Professor of Chemistry, Bryn Mawr College Summer School of Nursing, Bryn Mawr, Pa. Revised with the assistance of MARIE C. D'ANDREA LOGAN, R.N., B.S., M.S. (Nursing Education). Ready in April. 6th edition, approx. 450 pages, 6½" x 9½", approx. 165 illustrations. About $5.25.

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Random Comments

Dear Editor:

My thanks to Fay Beek, New Brunswick, for her very informative and much appreciated reply (*The Canadian Nurse*, December) to my query re: treatment of bed sores with laundry soap.

We are very fortunate in being able to present our problems to the many subscribers to *The Canadian Nurse*.

JANE LEWIS, Manitoba

Dear Editor:

The "Cumulative Index" is an excellent piece of work and has proved most useful for locating material that students were unable to find in the *Outlook* or *A.J.N.* index.

I would like to have you send us another copy of the November, 1960 issue, which contained the series on nutrition. Our copy has been used so much that I will need a new one for our bindery files. The articles were well written, brief and to the point.

HARRIET ALBRIGHT,
School of Nursing Librarian,
Augustana Hospital, Chicago, U.S.A.

Dear Editor:

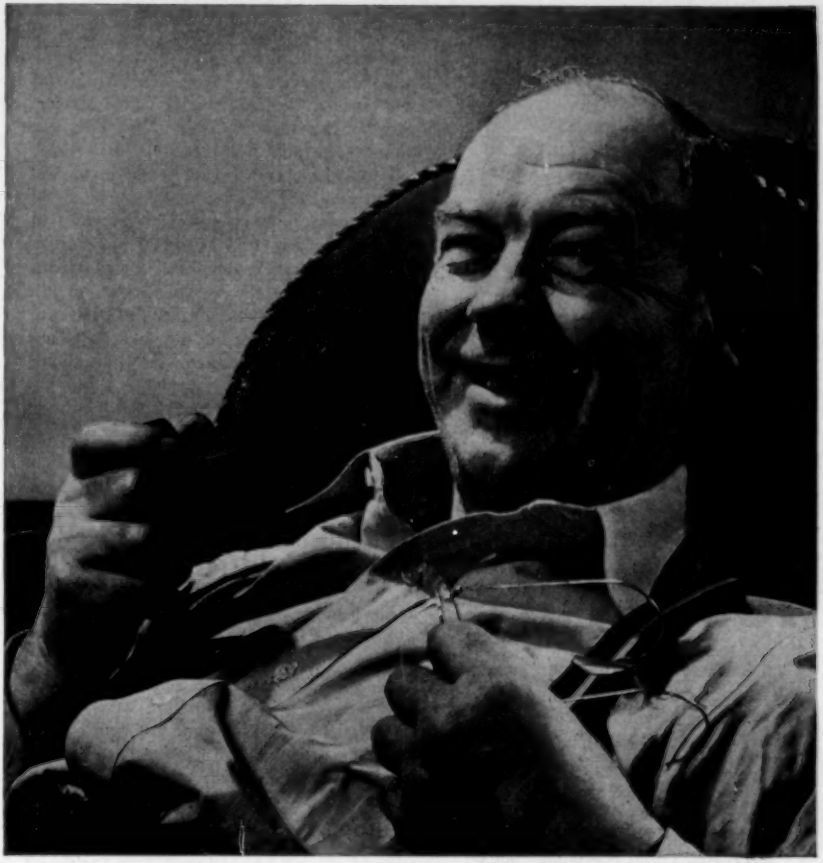
I read your fine magazine, *The Canadian Nurse*, each month with much interest.

I read the article in the December, 1960 issue entitled "Our Nurses Plan Their Time" written by Miss Rita Ball, Director of Nurses at the Trail-Tadanac Hospital, Trail, B.C. I worked under her rotation plan this past summer as a practical nurse and liked it very much, as did all other practical and registered nurses with whom I worked. Thanks to Miss Ball for having written the article and *The Canadian Nurse* for publishing it.

PAULINE HEDIN, Saskatchewan

Dear Editor:

Congratulations on the most topical issue yet of the *Journal* (January, 1961), with articles and information of particular interest to basic nurses who are anxiously asking "Where are we going, and how?" I refer specifically to the articles on Communication (pp. 19 & 23), and Philosophy and Curriculum (p. 33) with the realistic and so thoroughly honest outlook of Florence Elliott, as when she questions "our integrity in our relationship to the students." I liked especially the article "Group Action" (p.



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59), with at last a glimpse for all of us who knew this was underway but not its conclusions. Do hope the latter will be followed up and not be pigeon-holed.

It was not made clear in the thought-provoking article "Visiting Nurse" (p. 46) why such a "bedside visiting nurse service" was not provided by the V.O.N. That service is not available in Kamloops.

If only some nursing directors in Canada would read and live up to the words in the second paragraph of the filler on page 44. Have just been told of another group of British nurses returning to Britain, vowing that they will tell everyone there of the "dishonorable, dishonest and deceitful attitudes" of certain nursing directors they have met here. It is very sad for our international reputation.

A. Cecilia Pope, Ontario

Dear Editor:

Please change my address plate to my married name. I want to congratulate you for the present method of mailing the Journal. It always arrives in good condition.

F. Boily Vialle-Soubranne, Quebec

Dear Editor:

For some time my Journal has been arriving in a poor condition, dirty and torn. Would it be possible to send them out in envelopes as was done in the past? Several of my friends have the same problem.

In the present condition they are difficult to read and I do not care to add them to my library.

Jeannine Fiset, Quebec

¶*The Journals leave the office in perfect condition, damage therefore occurs either at the local post office or en route to your home from there. Others have solved this problem by consulting their local postmaster and/or letter carrier.* Ed.

Dear Editor:

I am fully aware that the following statement appears at the front of each issue of the *Journal*. "The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of *The Canadian Nurse* nor of the Canadian Nurses' Association."

At the same time I find it strange that a French-language publication would allow the following remarks to pass: "In 1755, the majority, then known as Acadians, were deported to Louisiana because of their hostility to the British." (May, 1960, page 422)

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school. According to Article 14 of the Treaty of Utrecht (1713), the Acadians "who wanted to remain under the domination of Great Britain, must have the right to liberal exercise of their religion" and the others "have the liberty of leaving within one year with all their moveable effects." But apparently the English employed many methods to hinder the Acadians from leaving their country "in the space of one year," after which they tried to make them pledge allegiance to the British crown. The Acadians refused and wanted to emigrate to Cape Breton. But the English opposed it for two reasons:

1. The departure of the Acadians would result in the economic ruin of Nova Scotia (their land was well cultivated),
2. this group of emigrants constituted a valuable increase in population for New France which had already caught the eye of England.

So, from 1713, Acadia, although living under English occupation, remained French in heart and soul. But by 1755, other aspects of the situation had changed. Halifax had been founded — consequently, there was no longer a need for the Acadians to develop the colony and fight the savages.

Secondly, the Acadians' well-cultivated land caused envy among the English colonists. The Seven Years' War virtually began in 1755.

Afraid that the Acadians would revolt and ally themselves with other French colonists, Charles Lawrence, the governor of Acadia, did not want to keep the Acadians in Nova Scotia; nor did he want to let them emigrate to other French colonies where they would have strengthened their numbers.

These are the true reasons for their deportation to Louisiana.

ALMA BÉRUBÉ, Quebec

Dear Editor:

While making up the annual volumes of journals for our nurses' library at canton de Vaud, we discovered that the July and August copies of the *Journal* had disappeared.

I am pleased to have the opportunity of telling you that *L'Infirmière canadienne* is very much appreciated and you will be receiving many more requests for subscriptions from French Switzerland.

RENÉE JATON, Editor,
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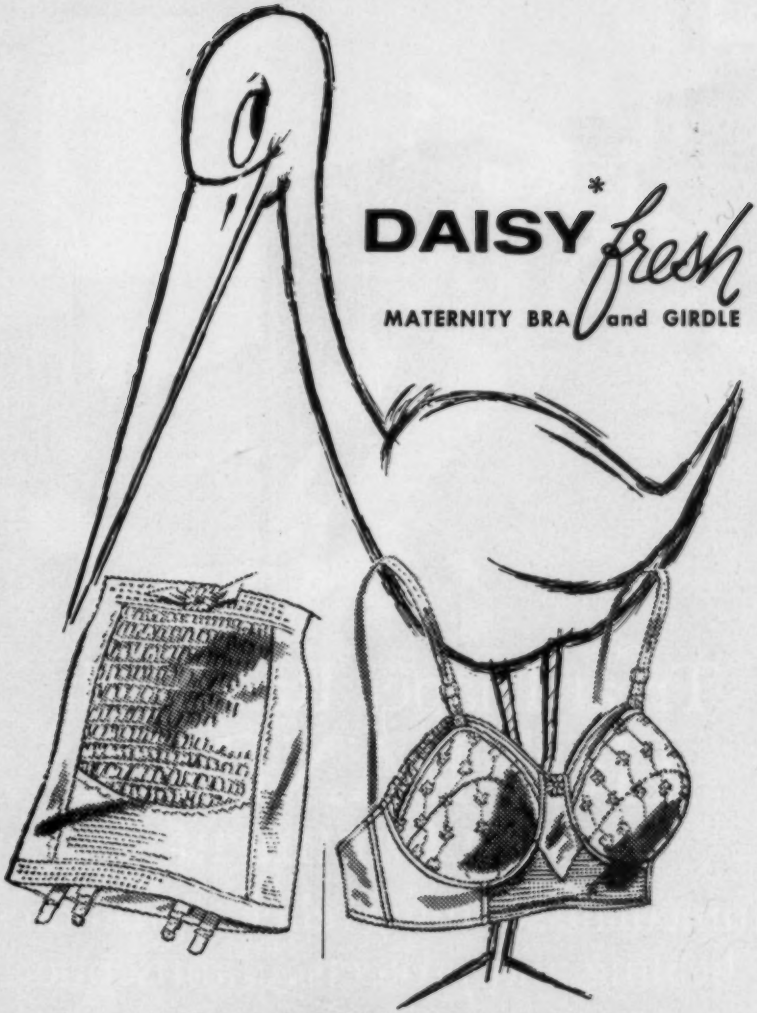

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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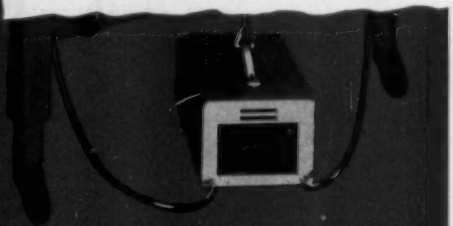

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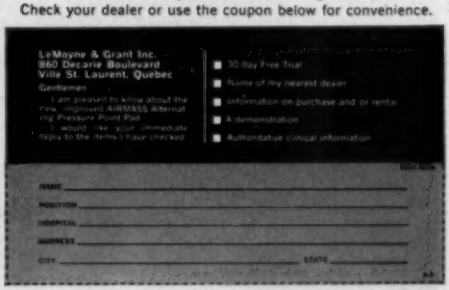
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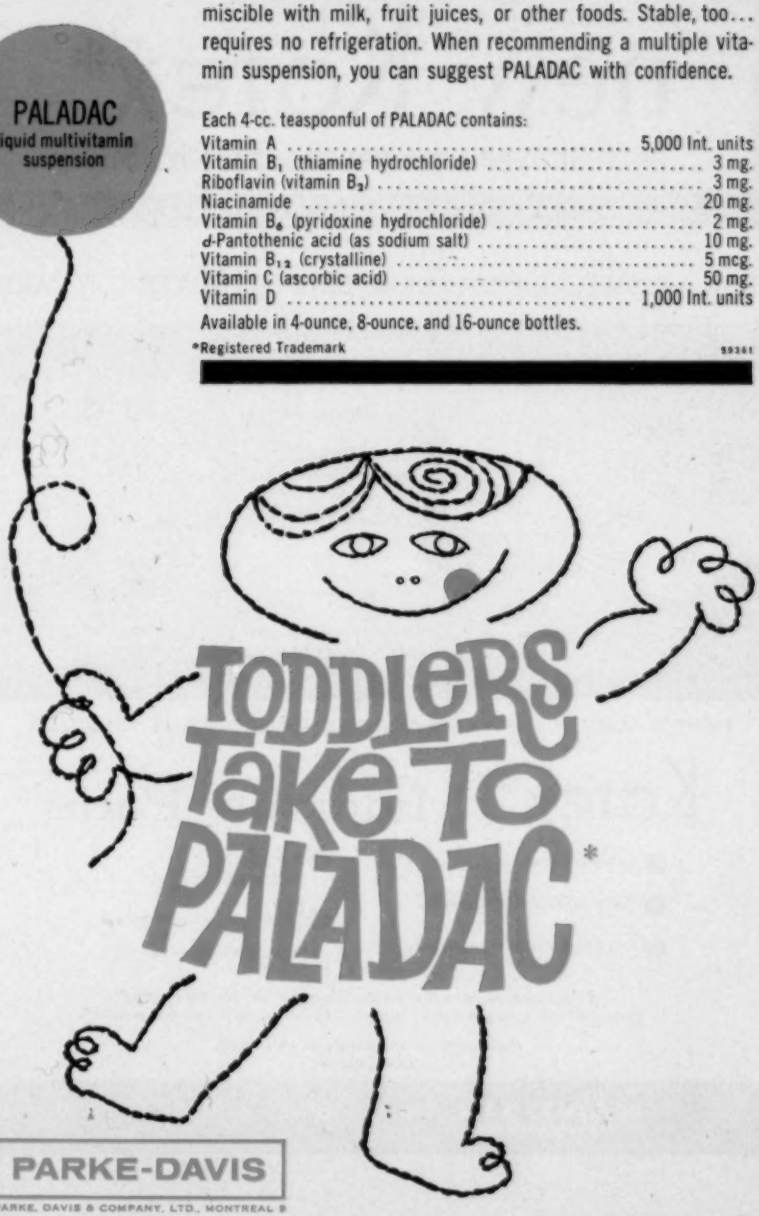

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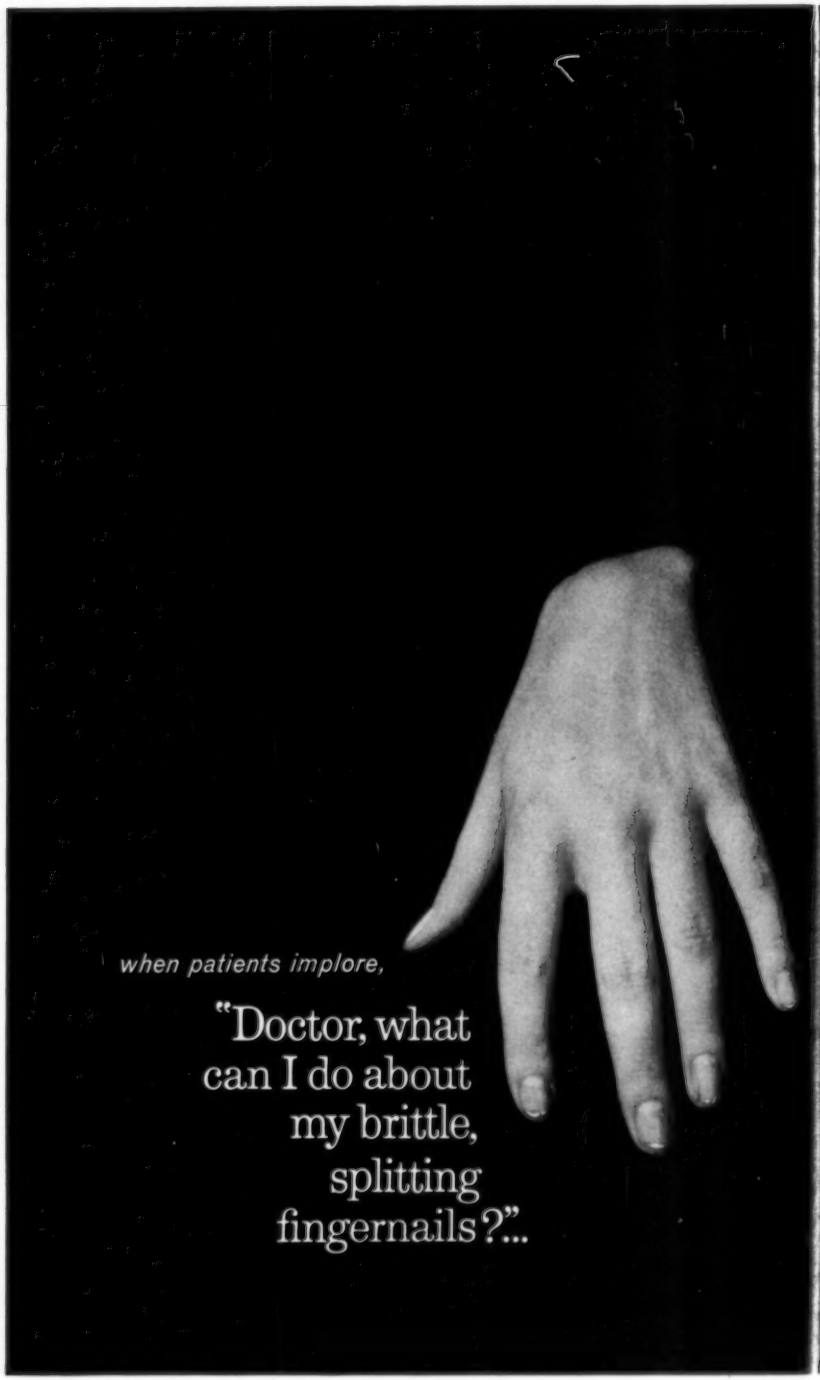
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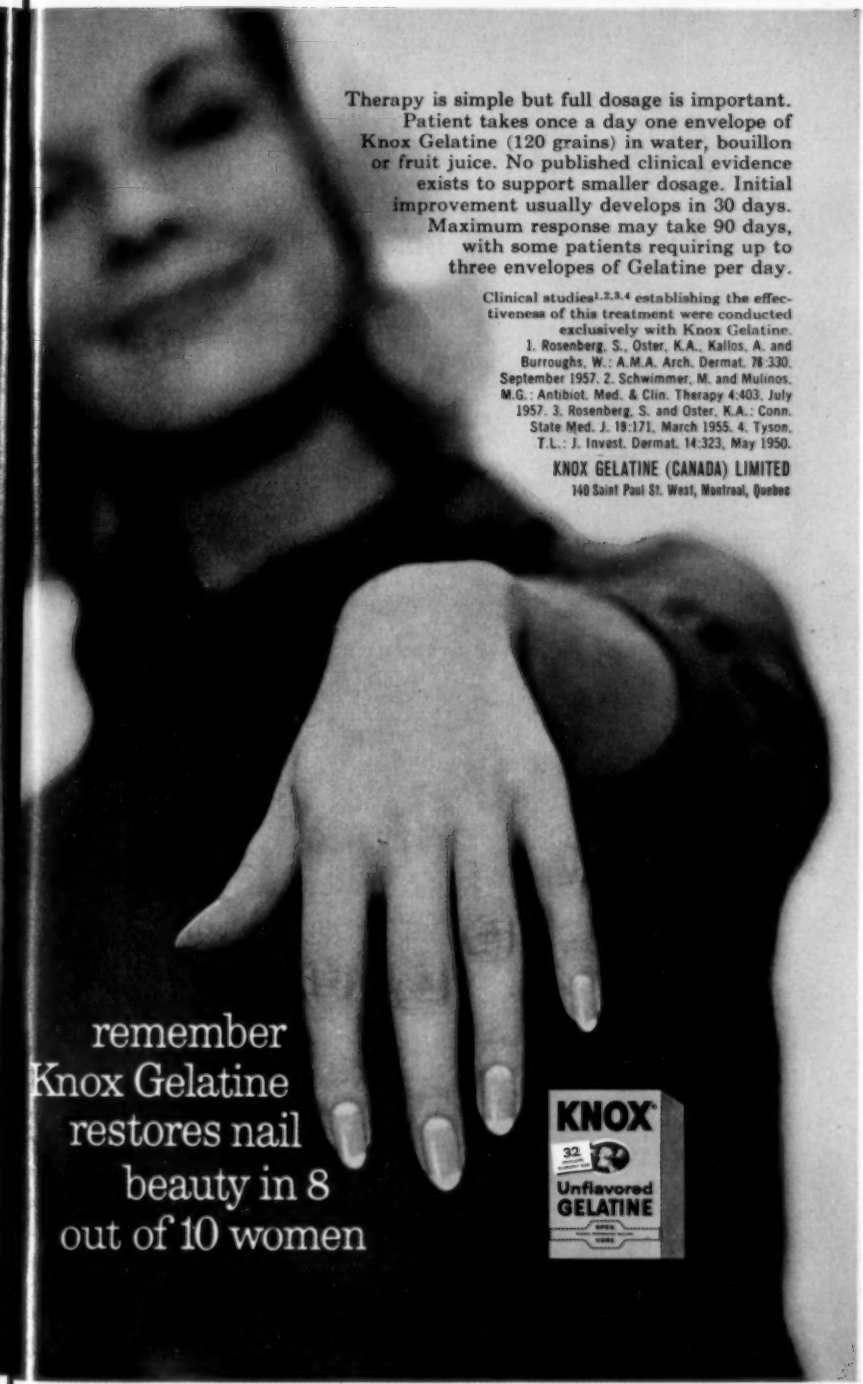
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1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957. 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957. 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955. 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.
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A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 57 NUMBER 4

MONTREAL, APRIL 1961

HORIZONS UNLIMITED

In reviewing the present activities and aspirations of the Registered Nurses' Association of Ontario, one must turn back in recognition of those nursing leaders of yesteryear and yesterday, who have made today possible. Their vision reached beyond the immediate horizon, beyond the hospital corridor, the end of the street, or the turn in the country trail. They must take pride in viewing their qualities reflected in the faces of many nurses whom it has been their privilege to influence. To each succeeding generation is given the responsibility of accepting the challenge of those who laid the foundations and to broaden horizons for the future.

Ten decades ago, Florence Nightingale established the first Nightingale School associated with a hospital; a decade ago the Demonstration School of Nursing in Windsor, Ontario, confirmed the belief of many nursing leaders that there should be a change in nursing education; today in Ontario we have the establishment of the Nightingale School of Nursing based on concepts from the past, but in addition, being developed by the leadership and vision of present nursing leaders. Present-day developments in nursing educational policies have created a need for definite soul-search-

(Ballard & Jarrett, Toronto)

ELLA M. HOWARD

ing on the part of all who have the responsibility for the education of the student nurse.

In nursing legislation, the Association has had a vision of what it wished. In the 1950's, while changes were made in nursing legislation, all that was desired was not accomplished. Now, in the 1960's it is our hope that nursing legislation may be changed to provide for a College of Nurses (composed of the nursing profession) as the statutory body controlling the minimum standards of education and practice for nurses in this province.

Within the RNAO organization there have been recent changes — the new building — increase in staff at provincial office to 12 professional and 32 clerical and secretarial members — the appointment of nursing consultants in Nursing Education, Nursing Service, Personnel Relations and an assistant executive secretary. All of these are indicative of growth, of the desire to give a better service to the ever-increasing number of nurses and to plan for future developments.

It is with regret that we announce the retirement of the executive secretary, Miss Florence Walker. To her will be given the deep admiration and sincere thanks of thousands of nurses.

Additional districts have been formed and these again divided into a number of chapters. Committee activity at provincial, district and chapter level continues to increase. Approximately 228 nurses act on a total of 38 committees and sub-committees on a provincial level alone. The contribution to the profession and the personal value to the individual nurses of such participation cannot be over-estimated. In addition there are the many who participate on working parties and special committees such as the Male Nurse Committee, and Advisory Committees, etc.

The Association sponsors annual conferences and institutes and has conducted studies on Personnel Policies, Examinations, and presently, on Nursing Registries.

Hospital nursing services in the province are receiving valuable assistance from the four nursing consultants associated with the Ontario Hospital Services Commission.

A personnel security program has been established and a nursing consultant in Personnel Relations appointed to provincial office. Under this voluntary program, assistance is given to individuals and groups of nurses concerning employment relations.

Membership in the RNAO has increased steadily, reaching a total of 24,092 in 1960. Due to the large numbers of members, the size of the province, and the necessity of holding annual meetings in one centre, voting by delegates has been introduced.

The annual meeting has become three days of business sessions with the attendance over 2000 in 1960. More microphones are added annually. It has been suggested that a sign "Take one and wait your turn" be placed by the microphones. This is indicative not only of the numbers, but of the participation. We like to feel it is a sign of maturity.

These are some of the areas in which we think horizons are broadening. It has been said that we cannot leap to heights, we were meant to climb. However, to day-dream about achievements can be inspiring, objectives can be clarified, purposes set, ways to reach them defined and then we all can get busy. The Association agrees that its nurses are *busy*.

May I again pay tribute to our former leaders; express thanks to the many presently guiding the destiny of nursing in this province; and express confidence in those of tomorrow that their vision will make the horizon unlimited.

ELLA M. HOWARD
President, RNAO.

There are two days in every week about which it is useless to worry. One is yesterday with its mistakes and cares, its faults and blunders. The other is tomorrow. It too, is beyond our control. Tomorrow's sun will rise either in splendour or behind a mask of clouds — but it will rise.

That leaves today and usually our present trials are easier to bear than remorse for what happened yesterday, or dread of what tomorrow may bring. Let us, therefore, journey but one day at a time. — *Anonymous*

Neurological Evaluation of the Infant

WANDA SCHIFFMANN, M.D.

This is the first section of a very comprehensive study of nervous system function in the young child.

Introduction

THE VALUE OF a neurological examination to determine the exact state of a child's development is obvious. The young child and his neuromuscular system have been discussed by many experts, for example, Gesell. The aim of this study is to review the various neurological changes at different periods during general development and to indicate the correlation between neuromuscular development and maturation.

A thorough neurological examination requires a series of long, and sometimes tedious, tests which can be carried out with comparatively little trouble on adults and older children. This is not the case when applied to young children, especially those under two years of age. Often examination must be reduced to subjective appraisal by the examiner. The findings vary markedly with the age of the child and the degree of development attained. On the other hand, these variations are specific indices of the extent of the neuromuscular and neuropsychic maturation that has been attained by the child.

The evaluation of human development from the neurological standpoint is based in large measure on the study of different types of behavior. The infant and young child may be judged fairly accurately as to intellectual development by observing spontaneous activity, posture and behavior. Specific aspects of behavior are related to definite neuro-anatomical structures. However, the correlation between structures and functions in human development is still largely theoretical. One can only assert general ideas with certainty. It is impossible to take all individual variations in neural structure into account. There has also been insufficient opportunity to establish proof through postmortem examination.

Dr. Schiffmann is on the staff of Ste Justine's Hospital for Children, Montreal.

Anatomy and Physiology

The cerebral cortex is the last of the structures to appear and reach maturity antepartum. After the sixth month intrauterine, the brain substance becomes firmer and the cortex starts to assume the histological characteristics of the human. There is more pronounced differentiation between white and gray matter and the pyramidal bundles of fibres appear. By the eighth month all of the primary grooves are present. The secondary grooves continue to form for several months postpartum.

The newborn exhibits an anatomical foundation for differentiation between two types of behavior, that proceeded by the cortex on one hand and the subcortal cells on the other. Cortical behavior is characterized by latency in response and an element of deliberation. There tends to be great diversity in response. Subcortical or nuclear behavior is characterized by an immediate response that tends to be stereotyped and limited.

Newborn behavior is under the control of primary subcortical cells. The cortex, as it develops, takes over control of certain neuromuscular functions and exerts an inhibitory effect on some functions of the subcortical cells. Development, then, can be expressed through decrease in function as well as by increase or acquisition of skills. For example, the Moro reflex which appears to be under subcortical control is inhibited as the cortex matures. However, the newborn yawns, coughs and sneezes as well as he ever will because these are activities of the mesencephaly and diencephaly whose neuromotor aspects are mature at birth. Later, as development progresses, it becomes possible to demonstrate that some of these actions have a deliberate or voluntary stimulus. For example, the older child will cough to

attract attention. Thus the cortex is brought into play.

In summary, the newborn resembles the decerebrated animal whose motor responses are purely reflex. The simplest acts involve spinal arcs; those of a slightly more complex nature involve the subcortical structures and the cerebral trunk. Immature cerebral function can be demonstrated through the absence of intentional voluntary activity and inhibitory control.

During the first six months of life, cerebral influence becomes more and more evident and intentional activity develops. At the same time, certain reflex actions are progressively inhibited. If they persist, a pathological condition should be suspected. Cortical maturation is also associated with developmental changes in overt behavior. It is reflected by a decrease in some types of behavior and by the emergence and integration of other activity with neuromuscular function.

There is also a relationship between the development of function and myelinization. There appears to be a close parallel between the two although function can appear to a certain degree even in the absence of myeline. Myelinization begins about the 16th fetal week. The first areas to become myelinized are the centres of correlation in the cerebral cortex. This process continues until all of the principal fibres contain myeline in abundance. This takes place toward the end of the second year. The nerve fibres thicken and continue to do so even after they are completely myelinized. The process follows a definite phylogenetic sequence, the oldest fibre being myelinized first. All of the relay tracks and fibres which have a connection with fundamental vital activities have undergone the process by the end of the seventh fetal month. Consequently, the child born prematurely after this time has a relatively good chance for survival.

It is interesting to note that the earliest date at which reflex action has been observed was during the eighth week of gestation. Another writer reported the presence of irregular, arrythmic, uncoordinated, vermiform movements of the body and extremities between the second and fourth intrauterine month.

Examination

After a review of these fundamental ideas of development, morphology and physiology, it becomes easier to understand the variations to be found in the results of neurological examinations done at intervals during the early months and years of life.

Clinical neurological examination of the child as of the adult, involves the same main features:

1. General inspection;
2. the head;
3. the cranial nerves;
4. the motor system;
5. the sensory system;
6. the cerebellar system;
7. the autonomic system.

In the child one must pay as much attention to the various types of behavior as to the development of various functions such as grasping and locomotion. Clinical examination may include, if considered necessary, radiography, electroencephalography, nerve and muscle testing with electrical currents, biochemical and psychometric testing.

A good patient history is invaluable, especially when a child is involved. Conditions of neurological disorder in children fall into three main categories.

a. Those of congenital origin, present at birth, resulting from a prenatal disorder or occurring in the wake of a birth injury. In these instances, it is important to know what the baby's condition was at birth, the type of labor, the infant's development during the early months of life. It is also useful to know the date on which fetal movements were first noted and the vigor of them.

b. Those which appear belatedly and insidiously such as degenerative conditions, chronic infectious conditions, certain cerebral malformations. In this instance it is helpful to know something about the familial antecedents.

c. Those which are of an acute nature such as encephalopathies of toxic or acute infectious origin or post-traumatic.

General Inspection: The older the child, the easier it is to evaluate his general condition and degree of development. This is especially true when the child it at an age when he plays in his bed and looks at the examiner with as much attention as he receives. It is so easy for symptoms to pass un-

noticed in the newborn since he is so passive and sleeps so much.

The newborn does not laugh or smile but he yawns, stretches and cries easily if stimuli are disagreeable to him. His crying is accompanied by a slight, generalized motor disturbance with an increase in muscular tonus. His cries should have a normal tonal quality and should stop quickly when stimuli are removed. Tears do not form before the second week.

At rest, the infant's respirations are rapid, somewhat irregular, and readily affected by external stimuli. However, periods of apnea must be considered pathologic. The pulse also tends to be rapid and irregular.

The Head: The shape and size of the cranium have particular significance because it is comparatively easy to recognize an increase or decrease in the volume of the cranial vault, a flatness or asymmetry of the spheres that is quite apart from the moulding normally seen after birth. The growth of the brain is exhibited exteriorly by the development of the skull. At birth, the brain has attained 25% of its mature size. During the first year of life it reaches 50% of its size and approximately 20% more during the second year.

Comparison of the size of the skull with general body proportions produces certain exact signs of growth. At birth, the height of the head is about one-quarter of the total body height. At two years, it is one-fifth of body height; at six years, about one-sixth and in adulthood, about one-eighth.

The circumference of the head gives even more exact information. At birth, the head circumference and the distance from the pubis to the top of the head are equal. The circumference of the head is slightly greater than that of the thorax by about one to one and one-half centimetres. This difference persists throughout the first year. Around three years of age, these measurements are reversed so that the thoracic circumference is slightly greater than that of the head.

The condition of the fontanels must be checked. After six weeks only the anterior fontanel remains open. It closes between the ages of 9-15 months. The bony suture line does not unite before the age of four years. Up to that age, percussion of the suture line will produce a "cracked pot" sound. In the older child this may indicate a diastasis due to an increase in intracranial pressure.

Cranial Nerves and Their Functions:

OLFACTORY NERVE: The sense of smell does not exist in the newborn. It continues to be absent or deficient in the first months.

OPTIC NERVE: The macula of the retina, the point of greatest sight, develops around the third or fourth month. Before this age it appears pearly gray. The optic nerve has a grayish appearance until the child is about two years old. It is only at that age that the pigmentation of the fundus oculi is completed. A false impression of optic atrophy or degeneration might be gained from the above.

In the premature baby, the optic disk may appear poorly defined, clouded, even edematous. There may be some opacity in front of or behind the crystalline lens due to vestiges of the *tunica vasculosa lentis.* These anomalies are more evident when birth is premature. Generally speaking, they do not last long.

Vision develops in the baby toward the end of the first postnatal month. By the second month the baby can recognize his mother.

OCULOMOTOR, TROCHLEAR AND ABDUCENS NERVES: In a baby the light-motor reflex is stimulated by holding a strong light in front of the eyes. This produces blinking, arching the head backward away from the light (Peiper's optic reflex). At two or three weeks of age, the baby begins to fix his eyes on a light but he cannot follow it with smooth movements before the age of three to five months. For that reason strabismus cannot be considered as a definite factor before the age of six months.

TRIGEMINAL NERVE: The sensitiveness of the face and the areas innervated by the trigeminal nerve is very well developed from birth. A light touch on the lips, the cheeks or the nostrils will produce the "rooting reflex" and the sucking reflex. The corneal reflex is characterized by blinking of the eyelids and backward arching of the head such as is seen in Peiper's optic reflex. The chewing

reflex is very active, especially if it is looked for when the child is crying and the lower jaw is dropped.

FACIAL NERVE: Peripheral paralysis is easily recognized particularly when the child is crying but spontaneous movements of the face are difficult to evaluate during the first few weeks. Around the sixth week, the combination of facial expressions characteristic to the act of crying appear — the corners of the lower lip are drawn down, the upper lip is curled.

ACOUSTIC NERVE: The auditory nerve always warrants careful study. The reactions obtained in the very young child correspond to those observed in the adult. Labyrinthine reflexes are present from birth.

Hearing is at a minimum if not totally lacking during the first days of life since there is no air in the middle ear and the Eustachian tube is more or less impermeable. However, hearing starts to develop within a short time. Later a loud noise will produce blinking and the Moro or "startle" reflex. At two months of age, the baby can be soothed by music and will turn his eyes and head in the direction of sound. At four months, the baby can associate a voice with the person.

GLOSSOPHARYNGEAL NERVE: Establishing the presence of a pharyngeal reflex is of great importance. It is necessary to establish whether or not there has been any history of regurgitation through the nostrils at mealtime. Although it is difficult to test the sense of taste objectively, it exists at birth. The baby reacts by expressions of satisfaction such as sucking or by grimaces and tears.

VAGUS NERVE: The motions of the soft palate and the uvula during swallowing are noted at the same time as the pharyngeal reflex. One must also note if there is a voice and what its quality and timbre is.

SPINAL ACCESSORY NERVE: Because some of the fibres of this nerve anastomose with the cervical portion of the spinal cord, it is quite possible that a pathological lesion might affect the lower two-thirds of the trapezoid muscles. Thus, movements of the shoulder should be checked even if movements of the neck seem normal.

HYPOGLOSSAL NERVE: It is not easy to detect atrophy or quivering of the tongue in a child. It is even more difficult in the very young baby. One must not confuse abnormal smallness of the tongue (microglossia) with atrophy.

The Sensory System

In the older child, as in the adult, there are varying degrees of sensitivity. The only one that can be checked with accuracy in the baby is pain. This should be done by pinching the tissues and not by pinprick because of the danger of infection from the latter. The normal response is to pull away or the baby may cry and make defensive movements of the whole body. This sensitiveness is not very acute in the newborn. The baby is particularly sensitive to temperature. He cries if he is too warm or too cold. Tactile stimuli about the lips or nares will induce the sucking reflex.

The phenomenon of rostral projection can serve as an indication of mental retardation. Before the age of six years, this prominence may not be conspicuous. Persistence after this time in a well-developed child is very definite indication of mental retardation.

The Motor System

This part of the examination is, perhaps, the most difficult and the most complex. The child's performance must be related to the normal activities for his age group. Evaluation must include muscle tone, voluntary and reflex movements, general appearance, posture, activity and so forth.

Muscle tone is easily assessed if it is remembered that there is increased response during the early months of life, especially in the lower limbs and particularly if the baby is crying. The discovery of asymmetry of tone is important. Checking for spasm on adduction is valuable is detecting evidence of hypertonicity. Hypotonicity is characterized by increased passivity and may be associated with hyperextension.

Spontaneous activity: The movements of the young baby are not under cerebral control. It could happen that a baby, with lesions of the motor areas and pyramidal tract sufficiently severe to produce hemiplegia, might still give the impression of being able to move

all of his extremities equally well for several months after birth. Free movement of the limbs simply rules out lesions in the cerebral portion of the spinal cord and the peripheral nerves.

The newborn is extremely active while awake but because of his inability to withstand the force of gravity, he appears completely defenseless. Different muscle groups share in flexion and extension movements. When the baby is placed on his abdomen, rythmic movements of his arms and legs simulate the act of crawling until he eventually shifts his position. He can raise his head from the horizontal position, turn it from side to side. These movements are completely reflex in contradistinction to rocking motions of the head which the baby will begin to use after several weeks.

Early in life, the movements of the limbs and the body seem extremely uncoordinated, even choreo-athetoid, especially when the child is disturbed. They are bilateral and diffuse. Isolated, localized movements of one part of the body should be considered pathological. Intentional or voluntary movements occur around four months of age when the child tries to grasp objects.

Reflexes

Certain reflexes are characteristic of infancy and should be present only at certain stages of development. Once the particular stage has been passed, the presence of the specific reflex should be considered abnormal. Some reflexes which are present at birth or develop during the early stages of infancy persist indefinitely, They exist in the infant in a form consistent with the stage of development attained.

1. *Tendinous* reflexes are present from birth in the normal baby but are difficult to demonstrate. The response to stimulus appears overactive as compared to that found in the older child or the adult.

2. *Cutaneous abdominal* reflexes exist at birth in about 30% of babies. They develop completely around six months of age. A normal response to stimulus is seen at six months to one year of age. Before this, the response is diffuse and involves the lower limbs particularly.

3. *Plantar* reflexes vary during the early months of life. There may be flexion or extension although the latter predominates. Later, around two years of age, when myelinization of the pyramidal fibres is more or less complete, the response is extension. It differs from the Babinski reflex in that several muscle groups in the legs are customarily involved; there may be retraction of the leg and movements of the whole body. After two years of age, a response of extension should lead one to suspect a lesion in the pyramidal tract.

4. The *sucking* reflex is normally present at birth. It has been demonstrated *in utero*. It is one of the earliest actions performed after breathing. Touching the lips or the cheek near the mouth lightly is sufficient to produce a response. Normally this reflex disappears during the first year of life. Its persistence suggests a pathological condition. In certain instances of retardation, the sucking reflex may persist for several years.

5. The *"rooting* reflex" or, the test of the four cardinal points, so-called because the reflex response arises from the same direction as the stimulus, is exactly like that of a little pig searching for something to eat. To demonstrate it, simply touch the lips or the check and the baby will turn his head in the direction of the stimulus, open his lips, protrude his tongue and begin sucking. The child will seize an object in his mouth and continue to suck it for several moments even if his hunger is not satisfied.

6. The *grasping* reflex is established during the first weeks of life. Touching the palm of the hand lightly is sufficient to produce a response. His grasp is strong enough for him to hang suspended in the air for several seconds. This reflex is demonstrable to a certain degree on the sole of the foot. It reaches its maximum at the end of the first month and disappears between two and four months.

The ability of the baby to hang suspended from a parallel bar through the strength of his grasp is in contrast to the Moro reflex since it is later revived, not as a reflex, but under cortical control.

7. The *Moro* reflex is elicited by a sudden external stimulus such as a loud noise or a tap on the abdomen when the child is lying on his back. There is first abduction and extension of the four extremities followed by adduction and flexion, particularly of the upper extre-

mities. This reflex is present from birth but in some instances of obstetrical trauma it may be absent for several days. A unilateral response should lead to suspicion of a peripheral paralysis such as that following a lesion of the brachial plexus.

The Moro reflex starts to regress at the end of three months and disappears completely before the fifth month. Its persistence beyond that time is indicative of a neurological lesion. It may persist for some years in retarded children.

8. There is another complete series of reflex activities which are related to change in positions and which are executed through the medium of the labyrinthine pathways. The main ones to look for are:

A. *Tonic* reflexes of the neck. They are seen in incomplete form to the end of the second year. Their persistence beyond the third year is definitely abnormal. These reflexes are of the type seen in decerebrated animals. For example, turning the head towards one side produces flexion of the limbs on the opposite side and extension of those on the same side.

B. The reflexes of *balance*. 1. These are first seen in the second month and persist throughout life. If the eyes are covered to eliminate visual participation and the child is suspended in the air and shifted into various positions, the head moves so that the child tries to maintain the upright position. This is due to the fact that the stimulus originating in the semicircular canal of the ears initiates a reflex action in the musculature of the neck which leads to this response.

2. In the neck: This response is seen during the first year but regresses completely by the fifth year. If the head is turned abruptly, the movement is followed by reflex rotation of the shoulders and the hips towards the same direction so that the body lies in a straight line.

3. Landau reflex: This is only one combination of the reflexes of the internal ear and the neck. If the child is held horizontally face down, in the normal one to two-year-old there is an extension of the head, the trunk and the extremities so that the body is arched anteriorly. If the head is forced forward, the limbs and trunk also bend so that the body is arched posteriorly.

The reflexes of balance are used by the child who is attempting to change from the dorsal lying position. They are also seen in the so-called quadripedal stage which lasts to the end of the first year. The child first turns his head, then his shoulders and hips. When he is in semi-prone position, the arms are placed in extension to push himself into half-sitting position. If the child wishes to stand up, the lower limbs are extended and with the help of his arms he pushes himself to a vertical position.

The adult form of balancing develops normally during the latter months of the first year. This is differentiated from the first stage in that the preliminary rotation is no longer done. The body is raised by the flexor muscles of the thighs and the abdominal muscles.

9. The muscles of acceleration are interesting to study because they are among the most fundamental. They exist from birth and should be well developed at six months. They persist throughout life. The reflexes of *circular acceleration* produce responses that are precisely the ones sought for vestibular testing. These tests are not currently used for the infant nor the young child. The reflexes of linear acceleration are of two types:

1. The *falling* reflex: If one lets the child drop suddenly while holding him by the trunk, he raises his arms and puts his head in extension. Cessation of the movement of falling is seen to produce forward tilting of the trunk and extension of the four limbs.

2. The *lifting* reflex: At the start of the movement the baby bends his head and body forward, and the arms are held down. When movement stops the arms are raised while the head and trunk are in extension.

(To be concluded next month)

The man who has not anything to boast of but his illustrious ancestors is like a potato — the only good belonging to him is underground. — Sir Thomas Overbury

* * *

Art lies in concealing art. — Ovid

ERYTHROBLASTOSIS – The Nursing Viewpoint

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The purpose of this paper is to discuss the most common cause of severe neonatal jaundice, erythroblastosis, in the hope that with increased vigilance on the part of all nursery personnel, medical and nursing, this condition will continue to be recognized early and treated effectively.

Introduction and History

ERYTHROBLASTOSIS FETALIS results when maternal antibodies cause fetal red cell destruction, anemia and hyperbilirubinemia. These antibodies are produced against a fetal red blood cell antigen that enters the mother's circulation during the early months of pregnancy. Although there are many heritable, fetal red cell antigens, only three, the Rh antigen (D) and blood group substances A and B, are frequently encountered in the causation of erythroblastosis fetalis.

Incidence

Landsteiner, in 1900-1901, discovered two human red blood cell antigens, which he designated A and B, and their naturally occurring antibodies, or agglutinins, anti A and anti B. By the absence or presence of these substances the Caucasian race can be divided into four groups.

Blood group	*% of population*	*Antigens*	*Antibodies present*
O	43.5	A or B absent	anti A and anti B
A	39.2	A present	anti B
B	17.7	B present	anti A
AB	4.5	A and B present	anti A and anti B

Since 1901 several red cell antigens have been discovered, the most notable being the Rh antigen. In 1940, Landsteiner and Wiener found that the erythrocytes of 85 per cent of Caucasian individuals contained an antigen that was also found in the red cells of rhesus monkeys. These people are designated Rh positive, while the 15 per cent whose erythrocytes do not contain this antigen are named Rh negative. Although there are several varieties of Rh antigen the first discovered, named D, is responsible for the vast majority of cases of Rh erythroblastosis.

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Inheritance

The Rh antigen D is produced by the action of two genes, one inherited from each parent. If such a gene "D" is absent it is replaced by an alternative gene designated "d." These genes are each carried by a single somatic chromosome. There are three possible genetic, inherited combinations:

DD — a "D" gene from each parent — RhD homozygote — Rh positive

Dd — a "D" gene from one parent, a "d" from the other parent — RhD heterozygote — Rh positive

dd — a "d" gene from each parent — Rhd homozygote — Rh negative

The presence of even a single D antigen produces an Rh positive individual. The absence of a single D antigen produces an Rh negative individual.

RhD erythroblastosis can only occur in an Rh-positive fetus who is the product of an Rh-positive father and an Rh-negative mother. If this father is a homozygote (DD) all his children will be Rh positive and hence liable to the disease. However, if he is a heterozygote (Dd), statistically speaking, one half of his children will be Rh negative (dd) and hence escape the disease.

The importance of knowing whether

any father is homozygous or heterozygous becomes obvious.

Mechanism of Production of Erythroblastosis

Rh Disease

The erythrocytes of the Rh-positive fetus pass into the maternal circulation probably during delivery of the first baby (who is not affected). To the Rh-negative mother, this Rh-positive antigen is a foreign substance and her body reacts against it by producing "defensive" Rh antibodies. In the next pregnancy, if the fetus is Rh positive, small numbers of Rh-positive fetal red cells reach the maternal circulation. The mother's body, already sensitized to Rh-positive cells following her previous pregnancy, reacts violently with increased production of Rh antibodies. This increased level of maternal antibodies, eventually reaches the fetal circulation producing a "reaction" in the red cells. Because the Rh antigen resides totally in the fetal red blood cell the antigen-antibody reaction affects the red cell only, producing severe hemolysis and hence anemia and jaundice.

ABO Disease

This is very similar to Rh disease, except that the first baby is frequently affected. In addition, A substance is present in many body cells, so that any maternal A antibody becomes widely distributed throughout the fetus. The amount of antibody available for "reaction" with the blood cell is less and the reaction less severe. Thus, little or no anemia is produced and often only mild jaundice.

Sensitization

Maternal sensitization occurs by the passage of red blood cells, in Rh disease, most likely during delivery of the first pregnancy. Indeed Zipursky[4] has shown that fetal red cells are frequently found in postpartum women. Maternal sensitization can also be produced by giving an Rh-negative woman a transfusion of Rh-positive blood; one cc. is sufficient to cause such sensitization.

Rh Sensitization Frequency

What governs whether an Rh-negative woman pregnant with an Rh-positive fetus will become sensitized is unknown. If she is transfused with Rh-positive cells she stands a 90 per cent chance of sensitization. Yet many Rh-negative women never become sensitized; some may during the second pregnancy; some only after repeated pregnancies.

It is important to point out that about 14 per cent of marriages in Great Britain are between Rh-negative women and Rh-positive men. Eight of the husbands are heterozygous and six are homozygous. Thus 10 out of every 14 pregnancies will produce Rh-positive fetuses, that is, 10 of every 100 children born of Rh-negative mothers. Yet the total incidence of Rh hemolytic disease is only 1 in every 200 pregnancies, much less than the 20 in 200 if all Rh-positive fetuses of Rh-negative mothers were affected. Thus the Rh-negative mother with an Rh-positive fetus has a 1:20 chance of having an affected baby, and that usually only during the second or later pregnancies. The incidence is less than 1 per cent in first pregnancies.

The Pregnancy

All pregnant women should have their Rh determined early in pregnancy. If she is Rh negative the Rh-antibody level should be determined repeatedly during the last eight weeks of pregnancy. It will rarely be present during first pregnancies. Two types of D antibodies may be produced, one demonstrable in saline solutions, the other in protein media. Thus the saline agglutinin (antibody) is present in only 30 per cent of cases where antibody is found. The latter antibody, or albumin agglutinin, is more frequent. Both are important in the production of disease. The level of maternal antibody, particularly when determined after incubation at 37° C., is usually closely related to the severity of the hemolytic process. If there is a rapid rise toward the end of pregnancy and if there has been a previous stillbirth or neonatal death induction of labor at or about the 37th week may be indicated.[3]

The Fetus

The disease may be so severe as to produce fetal abortion early in the third trimester, or it may become rapidly fulminant near term producing a stillborn child.

Occasionally the child is born alive but is severely anemic and edematous. This is hydrops fetalis. Even immediate treatment may not save the child. Polyhydramnios is a frequent associated finding.

Most commonly, however, the child is moderately pale with an enlarged liver and spleen. He rapidly becomes jaundiced with increasing anemia, erythroblastemia on blood smear and reticulocytosis. Sensitized fetal red blood cells can be demonstrated by the direct Coombs' test. Unless treated, the hemolytic process may advance so rapidly as to cause death either from anemia or from a rapidly rising serum bilirubin, which in turn may do irreversible damage to essential parts of the brain, notably the basal ganglia. This latter state is termed kernicterus — the child is deeply jaundiced with a poor cry, poor sucking reflex and an absent Moro reflex. The head is severely retracted (opisthotonos) and the breathing shallow. If the child survives he is almost certainly destined to have severe choreoathetosis and mental retardation, although occasionally a perceptive deafness may be the only sequela of a previous kernicterus.

Treatment

Mother — No reliable method has as yet been found to prevent maternal sensitization in those in whom it is going to occur. As already mentioned the mother is allowed to go to term unless she has previously had a stillborn or hydropic baby.[1] It is hoped that the quantitative determination of maternal antibody by the indirect Coombs' test (incubation method) will allow us to select the most severely affected infants and deliver them before intrauterine death occurs.[3]

Child — 1. Blood cross-matched with the mother should be available in any and all pregnancies where demonstrable maternal antibody is present. Thus immediate exchange transfusion can be carried out if the child is born severely anemic.

2. Cord blood should be examined for hemoglobin content, bilirubin content, Rh grouping and presence of sensitized red cells (direct Coombs' test). A smear for erythroblasts and reticulocytes may be of assistance.

3. Clinical evidence of anemia, jaundice, petechiae, edema and hepatosplenomegaly is to be noted.

4. Generally, exchange transfusion is indicated if:

a. Cord hemoglobin is below 14 grams.

b. Cord bilirubin is above 3.5 mgms. /100 ml.

c. Premature infant (kernicterus more common)

d. Previous severely affected sibling.

Exchange Transfusion

The technique of this procedure is well described elsewhere.[2] Briefly, the slow exchange of compatible donor blood with the child's own blood is carried out, usually through the umbilical vein. The heart rate is constantly checked and if citrated donor blood is used additional Ca++ ions are given very slowly, after each 100 ml. of transfused blood. Repeat exchange transfusions are indicated if the serum bilirubin rises above 20 mg. per cent during the first five to six days of life.

Occasionally, severe purpura due to thrombocytopenia develops. Administration of adrenal cortical steroids may arrest bleeding. Simple transfusion for anemia may be needed, only rarely, during the first six weeks of life.

ABO erythroblastosis is rarely diagnosed until the child is 36-48 hours old when increasing jaundice is noticed by an alert nursery staff. Because of the rarity of severe anemia, jaundice and its sequela, kernicterus, is the only real danger to the child. Exchange transfusions are carried out to maintain the serum bilirubin at less than 20 mg. per cent.

Summary

Erythroblastosis due to Rh disease is more severe than in ABO disease. Its presence should be known prior to delivery but in the occasional case when it is not, careful nursery observation is imperative if severe sequelae are to be avoided. Because of the insidious progression of jaundice with ABO erythroblastosis, its detection depends entirely upon an *alert, well-informed nursing staff*. Similarly, complications such as bleeding with severe Rh disease, must be looked for assiduously by the nursing staff and prompt medical attention initiated at the earliest possible moment. It is only in this

way that we can continue to prevent the severe sequelae of erythroblastosis in these affected infants.

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In Memoriam

Doris (Nichols) Abbot who graduated from the R. W. Large Memorial Hospital, Bella Bella, B.C. in 1924 died December 16, 1960.

* * *

Lena Maud (Smirle) Baxter who graduated from St. Luke's General Hospital, Ottawa, died recently after a long illness.

* * *

Mary M. (O'Brien) Cruickshank, a graduate of St. Michael's Hospital, Toronto in 1924 died in Toronto on January 21, 1961.

* * *

Maria (Wilczynaska) Czupryk, a graduate of the University Nursing School, Krakow, Poland died in Kelowna, B.C. on November 26, 1960.

* * *

Erma (Imholtz) Finnerty who graduated from St. Paul's Hospital, Saskatoon in 1915 died during 1959.

* * *

Grace (Willard) Gallinger who graduated from Victoria Hospital, London, Ont. in 1927, died in Detroit on January 12, 1961.

* * *

Grace McIsaac (Inglis) Joyce, a graduate of Cumberland Infirmary, Carlisle, England in 1922 died in Windsor, Ont. on January 6, 1961. Mrs. Joyce was a director of public health nursing with the city's Board of Health and most recently had been a director of Metropolitan Windsor Health Unit.

* * *

Rose (Schmidt) Kaufman, a graduate of St. Paul's Hospital, Saskatoon in 1915, died in August, 1960.

* * *

Bertha M. (Lowrie) Kay who graduated from Riverdale Isolation Hospital, Toronto in 1929 died in Toronto on January 18, 1961.

* * *

Marguerite Anna (Meek) Killins who graduated from Memorial Hospital, St. Thomas, Ont. in 1924, died on December 29, 1960. She had engaged in institutional nursing.

* * *

Eva (Daley) Lambert who graduated from St. Paul's Hospital, Saskatoon in 1915, died in 1959.

* * *

Gladys Leeming a 1927 graduate of Connaught School, Weston, Ont. died on January 6, 1961. She had engaged in institutional nursing.

* * *

Marie Thérèse (Ménard) Massue, a 1936 graduate of Hôpital St. Charles, St. Hyacinthe, P.Q. died in Montreal during November, 1960 after a brief illness. She had served overseas during World War II, 1942-46, as a nursing sister with No. 17 Canadian General Hospital.

* * *

Loretta McGuire who graduated from Pembroke General Hospital, Pembroke, Ont. in 1927 died on May 8, 1960. She had engaged in private nursing.

* * *

Mabel Mae McMullin, a 1905 Canadian graduate of Lawrence General Hospital, Lawrence, Mass. died in St. Stephen, N.B. on December 18, 1960. She had engaged in private nursing and had held several offices in the local chapter of registered nurses.

* * *

Bernadette (Verrette) Morin who graduated from Hôpital St. Charles, St. Hyacinthe, P.Q. in 1929 died in Montreal on January 19, 1961.

* * *

Alice (Renner) Neilsen, a graduate of St. Paul's Hospital, Saskatoon in 1924, died in 1959.

* * *

Theresa (Parker) Zamojsky who graduated from Marymount School of Nursing, Sudbury General Hospital in 1959, died October 11, 1960 after a brief illness. She was on the staff of the hospital at the time of her death.

The Preschool Years – Prevention of Disease

M. Dantow, B.S., M.B., D.P.H.

Health has been defined as "A state of complete physical, mental and social well-being and not merely the absence of disease." This is a positive concept, indeed, a challenging one and should act as a guide in any approach to the problems inherent in the prevention of disease during the preschool years.

The Preschooler Period

The period from the end of the first year to the beginning of school is probably the one in which medical supervision is most neglected. Mothers have learned to bring their children to the doctor for supervision during the first year of life, largely because of the need for specific advice concerning feeding and immunization. As the child grows older and specific physical problems are less obvious, visits are likely to decrease even though he is brought for booster immunizing injections. Interest may be maintained if the mother is convinced that the physician has something to offer in the way of supervision of growth and advice on guidance problems.

This period is one of relatively slow growth. With an average yearly weight gain of less than five pounds, the child who tripled his birth weight in the first year of life, will only double his one-year weight by his sixth birthday. He will double his birth length during his first six years, but because he grows relatively more in height than in weight, he appears tall and thin.

The rapid changes of fetal and infant life have largely been completed by the end of the first year and the child is busy learning to coordinate the motor mechanisms and functions that have been developing up to this time. He has learned to walk and talk. He has a tremendous interest in the world around him and explores it with physical activity that may tax the patience of his elders. This is his way of learning and developing and it must be supervised carefully and tolerated wisely.

Dr. Dantow is Medical Health Officer for the city of Saskatoon, Saskatchewan.

Preventive Medicine

In recent years there has been acceptance of the view that any disease process evolves from and is a result of, multiple causes that affect the interaction of man, disease agents (animate and inanimate) and the environment. If this is true it may be possible to interrupt the process by altering one of these three elements so that interaction does not take place or, failing this, by altering the process in favor of the human host. Most available preventive measures operate best when applied to individuals who are still unaffected or in whom the disease process is in its early stages. But preventive measures are possible even after the disease process has become well established. Consequently, there are five levels of application of preventive medicine — health promotion, specific protection, early diagnosis and treatment, limitation of disability, and rehabilitation.

Health promotion

With the advent of antibiotics and numerous technological advances in medicine, there has been a tendency to minimize or overlook the beneficial effects of health promotion. However, promotion of health in the positive sense through nutrition, personal hygiene, satisfactory environment and healthful living habits is definitely related to the prevention of many communicable diseases. By indoctrinating individuals and families with suitable principles of healthful living, the physician and nurse promote health and help prevent infectious and other disease agents from gaining access to the tissues. Adequate nutrition is an important factor in increasing resistance to tuberculosis. A definite relationship exists between nutrition and the risk

of acquiring enteric diseases, e.g. salmonellosis, shigellosis (dysentery). A higher infective dose of a microbiological agent is required for infection to be produced in a well-nourished individual than in one who is in a poor nutritional state. Hence, the adequately nourished child has a better opportunity of escaping illness on ordinary exposure to certain disease-producing agents.

Over-exertion and excessive fatigue are thought to convert subclinical poliomyelitis into severe disease with paralysis. Good living habits and customs of life which minimize exertion and fatigue are positive measures that prevent communicable diseases and their complications.

The influence of crowding on the transmission of infection is well known. It bears a direct relationship to meningococcal infection and other communicable diseases. The prevention of crowding decreases the probability of effective contact with infectious agents. Promotion of health through the application of principles of good housing reduces infection and disease. Good personal hygiene further minimizes risk of infection and risk of transmission. The simple hygienic act of handwashing can make person-to-person transfer of enteric pathogens impossible. Personal cleanliness prevents pediculosis and other infestations and infections.

The promotion of health through health information, instruction and education is important in communicable disease control. Knowledge of the fundamental facts of disease is an individual and community asset.

Specific Protective Measures

In considering the application of specific protective measures, a variety of attacks is possible. Children can be immunized against a number of communicable diseases and efforts can be made to eliminate infectious agents from the environment and to prevent their transfer to new hosts. A discussion of the current measures employed against specific disease entities will serve as illustrations.

Active immunization: Beginning at three months of age, an immunization program is recommended to prevent diphtheria, tetanus, whooping cough and poliomyelitis. Three doses of this quadruple antigen at intervals of one month are given as a basic course. A fourth booster or reinforcing dose is given 6-12 months later. The booster dose is regarded as essential for adequate protection. Additional reinforcing doses are given at three and five years of age. This is active immunization, whereby the tissues react to these antigens by producing antibodies of various kinds. The protection obtained is fairly durable but takes time to develop. Unfortunately, some parents find it difficult to appreciate this very important point. Not infrequently the doctor will see a child for the first time, after he has been exposed to one of the above-mentioned diseases (whooping cough is a good example). The child has not been immunized, but the mother is now anxious that he be given a "needle" or "shot" on the assumption that it will ward off the disease.

Vaccination: Smallpox vaccination should be done during the first six months of life provided there are no contra-indications. Excellent protection against this dreaded disease is obtained with a successful "take." If the first attempt fails, the measure must be repeated until it is successful. Parents are given a false sense of security when they are told that the child is immune because of the absence of a reaction. Even with a satisfactory scar, revaccination should be done before the child enters school.

It must be emphasized that protection against these diseases tends to wane with the passage of time. Hence, repeated booster doses are essential throughout childhood.

Selective immunization, based on the risk of exposure, is performed for such diseases as typhoid fever (T.A.B. vaccine), tuberculosis (B.C.G. vaccine) and many others which are not usually found in this country, e.g. yellow fever and cholera.

Passive immunization: Gamma globulin has an effect of short duration but it does provide immediate protection or modification of the illness, depending upon the dose administered and the time of exposure. This measure is utilized in a disease such as measles which is especially dangerous during the first three years of life.

Infectious hepatitis is prevalent in Canada now and is another disease in which gamma globulin has excellent prophylactic value.

Isolation and *quarantine* are other protective measures that are employed in accordance with provincial regulations. The purpose of isolation, contrary to views popularly held, is twofold: (a.) To prevent transmission of the infectious agent from the infected person to a susceptible host and (b.) to protect the patient from exposure to secondary infection by contacts with other persons during his acute illness.

Protection by *environmental sanitation* means the removal from the environment of living disease agents that have escaped from their human or animal reservoirs and are able to survive for varying lengths of time in the environment (animate and inanimate). This requires the employment of sanitary measures in handling vehicles of transmission of disease agents — water, food and milk. Protection may be afforded by: Sanitary supervision of food production; education as to proper protective measures in everyday life and methods of concurrent and terminal disinfection during disease processes; control of vectors, e.g. flies, lice, mosquitoes, etc.

Those who have been exposed to patients with scarlet fever or meningococcal meningitis may now be protected by the use of antibiotics. This is especially important at the present time. During 1959 and 1960 streptococcal infection — mainly scarlet fever and streptococcal sore throat — has been epidemic across most of Canada, the Western Provinces having been particularly affected. In most cases early and adequate treatment will reduce the period of illness and contagion and also help prevent serious complications such as rheumatic fever and nephritis. Contacts may be spared the illness by adequate prophylactic therapy over a period of three days.

Early Treatment

During recent years Saskatchewan has attempted to prevent recurrence of rheumatic fever by the introduction of a rheumatic fever prophylaxis program. The provincial department of public health will provide free penicillin to rheumatic fever patients over an indefinite period, if the district medical society will set up a committee to process applications submitted by the family physician. If the patient cannot tolerate penicillin, sulfadiazine will be provided.

Dental care is extremely important in this age group. The deciduous teeth number twelve less than the permanent teeth, but they fill the entire jaws until the latter begin to enlarge when the child is about four years of age. Caries of the deciduous teeth nearly always begin during the preschool years and may spread rapidly. These teeth act as guides for the positions of the permanent teeth. The deciduous second molars are especially important because permanent six-year molars erupt behind them, and tend to drift anteriorly under normal circumstances. This drift is exaggerated when a deciduous second molar is lost prematurely. As a result, the permanent canine teeth, which erupt late, may be crowded out of line. Periodic visits to the dentist, proper diet (including restriction of sweets), tooth brushing and fluoride, either topically or in the municipal water supply, will help prevent dental caries.

A condition known as *phenylketonuria* has recently been given increased emphasis in medical circles. This is an hereditary, recessive familial disease characterized by inability to metabolize the essential amino acid, phenylalanine, because of the deficiency of a specific enzyme. As a result, the amino acid accumulates in the blood and is spilled over into the urine in the form of phenylpyruvic acid. Severe mental deficiency is the most striking result.

Phenylketonuria can easily be detected in early infancy before the onset of mental retardation. If the disease is diagnosed early, proper dietary management can actually *prevent* mental deficiency. It has been claimed that a low phenylalanine diet may even produce improvement in established cases.

A low-phenylalanine preparation in powdered form is the principal source of protein in the dietary management of this condition. It can be mixed directly into selected low protein foods or be reconstituted into a milk-like drink by the addition of water. It is not yet known definitely how long such

a diet must be followed. Available evidence appears to indicate that a normal or nearly normal diet may be resumed at school age.

Routine testing of all infants for symptoms of phenylketonuria is now being done in certain areas. A simple test may be performed by placing a drop of 10 per cent ferric chloride solution onto the baby's diaper. The result is positive when an immediate bluish-green color appears at the site of application. This is a worthwhile screening program. One should not wait until signs of mental retardation are obvious before a diagnosis is made because then it may be too late. It has been stated that infants do not "spill" phenylpyruvic acid into the urine until the second or third weeks of life.

Management of the Diabetic Child

J. F. C. ANDERSON, M.D.

Agressive and continuous treatment in the care of the diabetic patient pays large dividends.

What is Diabetes?

DIABETES is a chronic condition, with a hereditary basis, in which there is an increase in the blood sugar (hyperglycemia), with excretion of sugar into the urine (glycosuria). It is the result of abnormalities in the pancreas involving the islands of Langerhans which, in turn, produce an inadequate amount of insulin.

Insulin is necessary for the proper utilization of sugar, and for the normal storage of glycogen in the liver, muscles, and other tissues. It also exerts a control in the utilization of protein and fat. Other glands of internal secretion, notably the pituitary, exert an influence on the pancreas. Increased destruction of insulin may be as important a factor in the onset of diabetes as defective formation of insulin.

Do we know the essential cause of diabetes? No! Is there a cure for it? None as yet but there may be in the future.

Incidence

There are probably 200,000 diabetics in Canada. The incidence increases with age. Under the age of 15, the ratio is 1:2500 population. For succeeding years the ratios are: 15-24 years, 1:1700; 35-44 years, 1:400; 55 years and over, 1:70.

There are estimated to be 9,000 *juvenile* diabetics in Canada — about 360 in Saskatchewan — all under the age of 15 years. Approximately five per cent of diabetics are in this age range.

Life Expectancy

Since the advent of insulin this has been increased by 21 years for the age group under 15 years of age. It is still considerably below that of the general population, ranging from 17 years of life less among the diabetic 10-year-olds to almost 4 years less among the 70-year-old diabetics. For those under 10 the mortality has dropped 99 per cent and for those of 60 years and over the mortality has dropped about 72 per cent.

For the individual diabetic, life expectancy may be much better than the average statistical figure as a result of:

1. Early recognition of the condition;
2. even temperament and good intelligence of the patient;
3. the degree of control exercised;
4. the prevention of ill-health and more effective measures to prevent complications.

Acidosis and coma are rarely encountered in the well-controlled diabetic. Complications such as eye, kidney, and arteriosclerotic changes are related very closely to inadequate control.

Dr. Anderson is the chief of medicine at the City Hospital, Saskatoon. He is one of the original members of the Canadian Diabetic Association and the organizer of the Saskatchewan Diabetic Association.

There are now a great many diabetics who are living much longer than their expectancy rate would be *without diabetes* because their lives are so carefully ordered. For example, it has been noticed that physicians who develop diabetes outlive physicians who do not have it.

The Symptoms of Diabetes

It is important for us to realize that often there are no particular symptoms, especially in adults. Classically they are:

1. Excessive thirst — polydipsia;
2. excessive hunger — polyphagia;
3. increased output of urine with a high specific gravity — polyuria;
4. possible itching — pruritis;
5. weight loss which often is marked.

The Diagnosis

1. In many cases discovery comes accidentally in the course of a routine urinalysis done:
   a. As part of a regular physical examination;
   b. following or during an illness;
   c. as preparation for operation;
   d. as part of a community program for discovery of early cases, "diabetes detection."
2. In undiagnosed, severe juvenile diabetes infection may give rise to diabetic coma and discovery of the diabetic condition is made during the clinical assessment of the patient.
3. In many cases the cardinal symptoms provide the clues to the diagnosis. Diagnosis is confirmed by:
   1. Finding glucose in the urine;
   2. the abnormal elevation of the blood sugar;
   3. the presence of mirco aneurysms in the fundi.

In some cases a glucose tolerance test is needed to discover the milder types of diabetes. This test should not be done as a rule if the diagnosis is otherwise quite evident.

Heredity and Diabetes

About one person in five has a known diabetic relative. If a diabetic marries into a non-diabetic family ordinarily none of the children will be diabetic or become diabetic. If a diabetic marries a diabetic 100 per cent of the offspring *should* develop diabetes. actually 50 per cent do. If a diabetic marries a non-diabetic from a diabetic family, that is one in which the father, mother, brother or sister is a diabetic, 50 per cent of the children should later develop diabetes, actually 25 per cent do. If two non-diabetics, both of whom are from diabetic families, marry, in theory 25 per cent of their children should develop diabetes. Actually 12 per cent do.

We are aware of a so-called prediabetic state. That is, it now seems possible to predict, with some degree of accuracy, the occurrence of diabetes before clinical symptoms arise. A new test has been devised called the cortisone-glucose tolerance test. Using this method it was found that out of 400 relatives of diabetics, 18 per cent had diabetes and 4 per cent probably had it.

General Principles of Treatment

1. Diet
2. Insulin and/or an oral hypoglycemic agent
3. Regular exercise

When these factors are properly adjusted we say that the person is in *good balance.*

The Objectives of Treatment

1. Freedom from abnormal glycosuria.
2. Freedom from abnormal hyperglycemia.
3. Maintenance of a normal nutritional state.
4. The leading of as normal a life as possible.

The diet should approximate the normal one for any individual. It should be convenient to prepare. The foods suggested should be easily secured. Meals should be palatable. The diabetic diet must contain sufficient *protein,* a moderate amount of *carbohydrate* (up to 250 grams) and *fat* in sufficient quantity to make up the required calories.

The constancy of food intake is important. Weighed diet are valuable from an educational standpoint but should ordinarily be replaced with a measured diet except in cases of very difficult balancing. Variety and substitution is very important if the patients are to remain content to follow their diets, day in and day out, year in and year out.

Insulin: Sufficient insulin and/or oral antidiabetic tablets are required

in all but instances of mild adult diabetes. No juvenile diabetic has been controlled successfully as yet on any oral preparation alone for a reasonable period of time. Combined insulin with DBI tablets offers the prospect of a reliable balance in some cases of juvenile and severe adult diabetes. There must be sufficient insulin to control glycosuria and hyperglycemia.

Types of Insulin

	peak action in	duration of action
1. Regular —	1 to 2 hours	6 hours
2. Crystalline —	1 to 2 hours	7 hours
3. Protamine Zinc —	12 hours	26-48 hours
4. Globin —	8 to 10 hours	18-24 hours
5. NPH —	8 to 10 hours	26-30 hours
6. Lente —	8 to 10 hours	26-30 hours

Combinations of these are often used especially in labile cases. In the treatment of acidosis and coma regular or crystalline insulin is always used.

Oral Agent versus Insulin

There are two types of oral agents:

1. The sulfonylurea group was released 1954-56.
   a. Tolbutamide — Orinase or Mobenol
   b. Chlorpropamide — Diabinese
2. The diguanide group was released 1957-59.
   a. Phenformin — DBI

These are products which lower the blood sugar. They have varying degrees of toxicity which often limit their usefulness. They do not lower blood sugar in all cases. They have, however, established themselves as very important instruments of treatment in selected cases.

The Sulfonylureas

Preparations belonging to this family ordinarily are used only in moderate to mild cases of adult diabetes.

1. Where the insulin requirements are less than 40 units;
2. in patients over 40 years of age;
3. in the absence of infection and complications.

Under such conditions the sulfonylureas prove efficacious in 70 to 80 per cent of cases. They are not used in the treatment of juvenile diabetes. In emergencies the patient is treated with insulin. He should carry a card at all times stating that he is a diabetic and how he is being treated.

The Diguanides

Krall of Boston has used DBI in 200 cases without any untoward symptoms other than nausea in some instances. Its mode of action if different from Orinase (sulfonylurea). It probably works at the cell tissue level. This drug seems to offer hope of being effective for the more severe diabetics, including the juveniles, but in no case has it totally replaced the need for insulin. It reduces the insulin requirement and seems to secure a more stable balance in those cases which tend to go quickly from a high to a low blood sugar level.

If a patient is doing well with a particular form of treatment it is usually unwise to change. Don't change because something is new! Don't swap horses in midstream!

Urine Testing

All patients should be taught to test their own urine regularly and to keep a record. At times specimens may be required *before* each meal and at bedtime, or after each meal and at bedtime. Twenty-four hour specimens are also quite valuable in determining how much sugar is wasted in any one day.

Juvenile Diabetes

Juvenile diabetes is defined as diabetes discovered under the age of 15 years. What factors make diabetes in children different from that in the average adult?

1. It is always relatively severe.
2. Fairly large doses of insulin are required.
3. The insulin requirements usually advance with growth.
4. The condition is usually more unstable.
5. A break in the dietary regime is of greater consequence.
6. Variation in exercise is likely to produce erratic results in the condition.
7. Insulin reactions tend to be more severe.
8. Diabetic acidosis and coma occur more frequently. It is the first manifestation in 15 per cent of the cases in this special group.
9. Growth and development may be retarded, especially under 15 years.
10. The symptoms, if observed, tend to be classical: Loss of appetite; loss in weight; pruritis; pains in legs; dehydra-

tion; thirst; large output of urine; bed-wetting and failure at school.

11. The caloric requirements are greater.

12. Infections are more common and often severe.

13. The emotional pattern is apt to be unstable.

14. Youth's normal rejection of regimentation creates problems in discipline.

15. Young people dislike to be different from their friends.

Age of onset

One of the main peak ages for the onset of diabetes in children is 12 years. Other peaks occur at 3 and 6 years. Twenty per cent of these children have a diabetic relative. Twenty years later 60 per cent will find diabetes among their relatives.

Character Building in the Child

Dr. Joslin has this to say:

> Properly brought up . . . he or she is more apt to develop self-confidence . . . a sense of responsibility, self-control, and unusual knowledge of his condition, more readily than the 50-year-old.

Proverbs 22:6 admonishes:

> Train a child in the way he should go, and in his old age he will not depart from it.

An understanding of the nature of his diabetes must be developed in the child, sufficient for him to comprehend the principles of treatment. He must learn what he may or may not have to eat and appreciate the importance of following dietary rules. He must be given an understanding of why he has to take insulin and must learn to measure and give his own dosage. He must learn to estimate the amount of exercise best for him. He must be taught to test his urine regularly and to interpret the results. In other words he must learn how to live with his condition and avoid possible complications.

We would cultivate the qualities of honesty, self-control, courage, hopefulness, common sense, wisdom and responsibility. We must seek to avoid pampering, creation of fear, discouragement, and emotional outbursts. We must help the child to learn to make the most out of life.

The diabetic child does not mean to be dishonest when he breaks ranks. Hunger and the instinct of self-preservation lead to breaks in his diet. Seek the truth in a logical manner rather than by emotional accusation. Use wonder and surprise. Have *him* help solve the problem of how to stay within the bounds of his diet.

1. The life of the diabetic child should resemble as nearly as possible the life of the normal child.

2. It is especially important that he should receive specific protection against infectious diseases.

3. Participation in athletics under supervision is to be encouraged.

4. He should learn to adjust his insulin dosage or preferably his CHO intake to meet the needs of exercise.

5. Every child needs a "buddy" someone to look out for him at school, at college and in play.

6. Summer camps are a splendid way to develop self-reliance and confidence.

7. Children love to assume responsibility. Give it to them.

8. Proper rest is important.

Insulin for the juvenile

The child diabetic always requires insulin and he should learn to give it to himself. Without insulin, mortality is 100 per cent. The child tends to have nocturnal hyperglycemia and glycosuria. His treatment must be planned to try to avoid the rising nighttime blood sugar. Isophane insulin or NPH insulin generally proves satisfactory. One-third of the patients will do well on NPH alone; two-thirds will require some regular insulin in addition.

Use of Insulin and DBI: If the juvenile is doing well, do not change from insulin alone. If a very high insulin dosage is required or if there is considerable instability in the child's condition then insulin and DBI tablets as a combination may prove effective.

The Factors in Exercise

A diabetic requires exercise in order to do well. Even bed patients should be given some exercise. Muscular activity lessens the amount of insulin required, because it lowers the blood sugar. When our muscles work they require glucose and use it up, but there must be a sufficient amount of insulin present to permit the proper utilization of the glucose.

Exercise is only harmful in the absence of adequate insulin. It is best taken following meals or following a carbohydrate lunch. The boy playing hockey, basketball, baseball, and such sports has to allow for the insulin-sparing action of exercise by either decreasing his insulin dosage for the day or preferably increasing the CHO intake before or/and during the sporting effort.

Diabetic youngsters can usually engage in their favorite sports under supervision. It is *regular* exercise, day in and day out, which counts rather than erratic bursts of activity. Exercise is invariably well tolerated and helpful if adjustments in food intake are made or if insulin is decreased.

Having a job to do is to be encouraged. "Work shortens the day, but lengthens the life."

Emergencies in Childhood and Adolescence

1. *Insulin reactions from hypoglycemia* are very disturbing to the child. They may:
   a. Cause embarrassment,
   b. interfere with athletics,
   c. interfere with school activities,
   d. act as source of discomfort,
   e. add to the sense of insecurity.

Reactions occur more easily because:
   a. There is less storage of CHO as glycogen in the young,
   b. erratic bursts of physical activity may produce hypoglycemia,
   c. there is a greater tendency to disregard warning symptoms.

2. *Causes of reaction:*
   a. Poor timing of exercise,
   b. undue amount of exercise,
   c. poor timing of food intake,
   d. inadequate intake of food,
   e. too much insulin,
   f. faulty methods of insulin administration.

3. *Prevention of reaction:*
   a. Careful timing of meals and insulin,
   b. correct dosage of insulin and technique in administration,
   c. anticipatory lunches before exercise,
   d. exercise should follow within ½ hour of eating,
   e. additional sugar should be taken during the effort if required.

Diabetic Acidosis and Coma

Diabetic acidosis is much more easily precipitated in the child than in the adult. The symptoms and signs are the same as for the adult but the onset and course is often much more rapid. The more promptly treatment is initiated the better the result and the less insulin that is required.

Symptoms of acidosis and coma:
1. General malaise,
2. anorexia,
3. fatigue,
4. muscle weakness,
5. nausea and vomiting,
6. pains in legs, back and chest,
7. abdominal pain,
8. thirst,
9. drowsiness,
10. air hunger.

Signs:
1. Dehydration — dry skin,
2. flushing,
3. odor of acetone on the breath,
4. appearance of shock,
5. Kussmaul breathing,
6. abdomen may be tender,
7. reflexes diminished or absent.

Laboratory findings:
1. The urine is loaded with sugar,
2. the blood sugar is high,
3. ketone bodies are found in the urine,
4. CO_2 combining power is low,
5. the serum potassium level usually falls.

Every hour of delay in treatment lessens the chances of recovery. One must learn to recognize the early signs of acidosis before coma occurs. Often the diabetic can be in serious danger without being too drowsy to be roused. He may be only stuporous and yet be in severe acidosis.

The Principles of Treatment in Acidosis

1. Insulin 2. fluid replacement 3. electrolyte replacement 4. search for and treat any accompanying infections.

One of the commonest mistakes in the treatment of diabetic acidosis is that of discontinuing or reducing the insulin dosage because of anorexia, nausea and vomiting, or fever. *More* not less insulin is usually required.

General Principles of Care

The continuing care of the diabetic juvenile or adult should include:
1. Faithful adherence to and constant balancing of diet, insulin and exercise.
Regular examination of the urine.

2. Regular physical examination to rule out intercurrent pathological conditions such as:

a. Acute infection for example, a boil,
b. tuberculosis,
c. heart disease,
d. respiratory disease,
e. oral and dental sepsis.

3. Regular visits to the supervising physician.

4. The possession of an authoritative manual for personal guidance.

5. Membership in the Canadian Diabetic Association.

6. Summer camps for diabetic children.

Complications

There are several outstanding complications which arise in juvenile diabetics:

1. *Proliferating retinitis:* In a study of 1000 juvenile cases, 28 per cent had developed retinitis when they were 20 to 29 years of age and 58 per cent had developed it between the ages of 40 and 49.

All cases were believed to have arisen from *lack of sufficient insulin.* This condition is not ordinarily seen before 15 years of age.

2. *Kidney damage:* This may become evident only after several years. Again it is believed that careful control of diabetes is the important preventive factor.

3. *Degenerative conditions of the arteries:* This is not seen under 10 years of age or prior to the fifth year after the onset of diabetes.

4. *Retardation of growth:* This is more apt to occur when the onset of diabetes has been under the age of five.

5. *Cataracts:* Occur in 1½ per cent of juvenile diabetics.

6. *Gangrene* is very rare under the age of 35 but is more common after the age of 60.

Coming!

in MAY 1961

Guest editor — Mrs. D. June Taylor, president, Alberta Association of Registered Nurses
Lehman — The New Orientation in Modern Nursing
Chittick — Inventing the Present
Logan — Nursing the Patient Today
Sr. Forest — Cooperation between Education and Service
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plus additional material

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The amount of the bursary will, to some degree, be related to the needs of the candidate.

Enquiries should be directed immediately to the:

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* * *

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ADOLESCENCE

F. E. COBURN, M.D.

Adolescence is a difficult period for every youngster. However, if they are prepared in childhood to cope with this period, it need not be fraught with personal or parental unhappiness.

Development Tasks

A USEFUL approach to the emotional problems of persons in any age group is to consider the tasks that confront them during that particular period of life. The tasks to be handled by the adolescent in our culture might be described as:

1. Maturation and emancipation,
2. handling of sexual strivings,
3. preparation for choice of a mate.

These are not separate activities but, rather, are quite interconnected. In our dealings with adolescents, whether as their parents or other adults, our concern should be to help them to handle these tasks and avoid actions or attitudes that might hinder or interfere with their success.

Maturation and Emancipation

Adolescence is the period in which the child makes the transition from childhood to adult status. He cannot solve his own problems, he does not have the capacity nor the experience to deal with our complex society, and therefore requires parental supervision and direction. Many of his needs have to be met by others. This can be summed up by saying that he is passive, receptive and dependent.

To be an adult is the direct antithesis. An adult should be able to cope with the problems that life presents to him and this with a minimum of direction and advice from others. He should be giving rather than receiving; giving, not of material things alone, but of consideration and understanding to other adults and to children. This behavior can be summed up in the words active, independent and giving. This is quite a transition to make and one which older people, especially parents, sometimes impede.

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We tend to solve the adolescent's problems for him rather than encouraging him to do it himself. We help him to be dependent by insisting that he accept our help, advice and direction. We give too much to him, and demand too little concern and consideration for others from him. This is usually done with the best of intentions. We underestimate both his ability to do these things for himself, and his experience and judgment. We fear he will make errors and be hurt by them, so we protect him from these errors. In so doing, we are, of course, in error ourselves. It is only by exercising his judgment that it develops; it is only by acting independently that he gains independence; and it is only by giving that he learns to give.

This overprotection may produce a person who is adult in years, but childish in outlook, unable to assume the responsibilities of adult life, and yet, compelled to marry and head a family by force of social expectation and sexual drive.

Another, less altruistic and usually unconscious motivation, to keep our adolescents in childish submission to us, is power. Many people have little power to command others in their adult life and yet, they gain great boosts to their self-esteem by having someone inferior to them whom they can direct. To such a person, giving up the control of adolescent children means a sacrifice of this power and the pleasure that attends it.

Overprotected children can react in at least two ways. One is by submission to our direction and control which produces an individual of little self-esteem and initiative who always has to be dependent on some authority figure. In adult life such interest in him and concern for him is not always forthcoming, leaving him frightened, angry and distressed.

The other reaction is rejection of

parental control. The adolescent just *has* to become independent. The struggle is sometimes a violent one because the parents are unwilling to relinquish their right to exercise judgment about what the adolescent should do. This often leads to such intense rebellion against parental standards that young people reject that which is good in their parents equally with that which is unwise. The result, at times, may be catastrophic misbehavior.

Such extremes can be avoided. If, throughout childhood, as the child's experience and judgment increase, we give increasing freedom and independence, by the time adolescence is reached the child is making virtually all his own decisions and has become an independent being. In the process he will make errors of judgment. He will have to suffer for these, but this is part of the *necessary* learning process by which we become adult.

Sexual Strivings

At puberty, the young adolescent develops physically in response to certain glandular changes in his or her body, including maturation of the sexual glands and organs. This maturation causes the youngster to have thoughts of sexual activity of an adult type. The child cannot avoid such thoughts and striving — if he were able to, our species would not be reproduced. The problem arises out of the fact that maturation of sexual functions occurs at about 14 years of age, while, in our complex society with its complicated roles to be learned, one is not ready to marry, establish a family and support it until an average age of about 22. How then can these sexual impulses be controlled for this eight to ten year period?

In the past we seem to have done it badly. The usual teaching has been either, to give little or no instruction in this important area or, to surround it with a sense of guilt, shame and wickedness.

How irreverent it is to teach children who are growing up that sex is nasty, dirty, animal-like and depraved! This is the method God has provided for our reproduction. The inference is, that He did a poor job by providing such feelings, desires and activities.

The child between the years of four and six usually goes through a period of intense curiosity about many things. What is more normal than wanting to know where he came from? The answer has been evaded with half-truths or out-and-out falsehoods about the stork, the doctor's black bag and the Easter bunny. Some children dare not ask the questions because of the shocked attitude of the parents. How much more wholesome to tell the child how daddy plants the seed in mother's body and how it grows and is born. This can be coupled by a very realistic and truthful exposition of morality. "Of course, we don't do that until we're married because every baby needs a grown-up mother to take care of it and a father to go to work and earn the money to buy the groceries."

Too many parents never face up to the reality of their children's sexual motivation in a realistic way. They try to control opportunities for contact with the opposite sex so as to prevent pregnancy, but do not help the youngsters to develop a really moral attitude. These very restrictions are apt to lead to rebellion and the very conduct feared by the parents.

Choosing a Mate

The choice of a mate is one of the most important choices an individual in our society will ever make. The choice may lead to a life of shared tasks, rewarding cooperation and delightful companionship or, to a hell-on-earth of bitterness, hostility and frustration. It is a task for which we need our best judgment. Judgment, of course, comes only with experience — in this case experience with *many* members of the opposite sex. Occasionally, someone says, "I married the first man, or woman, I ever went with" — a major decision made on a minimum of experience.

In some societies, marriages are arranged by the family or the clan. In ours, it is an individual responsibility and we must see to it that young people have had the experience necessary to make a wise choice.

Here, too, we adults sometimes interfere. Having done a poor job of sexual education, we fear premarital pregnancy and unwise marriage. Our response to this fear is an attempt to limit the contacts between the boys and

girls of this age, thus depriving them of the experience on which good choices are based. Another way in which we sometimes interfere is to set our judgment of personal or social compatibility against theirs. Surely the young people who are involved are better judges of whether they can get along together and enjoy one another than any outside observer. These parental objections often have the most unwanted results. The adolescent, who is in the throes of rebellious emancipation from parental control, is quite apt to marry the one disapproved of by the parents, just because of the disapproval.

Summary

Adolescence is a difficult period when youngsters are trying to establish themselves as independent adults, deal with their strange new sexual tension, and get to know the opposite sex. Let us, as adults, facilitate rather than impede these processes by understanding, lessening our controls, giving good sexual education and encouraging activities with many others of the opposite sex.

Impact of Hospital Insurance on Patient Care

R. A. Donahoe

Nurses are concerned with the implications that hospital insurance may have for their specific care of the patient. Other aspects of patient care also deserve mention in this same relationship.

The most obvious effect aroused by hospitalization plans has been an increase in the number of patient days provided to the public. 1959 showed an increase in excess of 10 per cent over the hospital days provided in 1958. The scope of the plan in respect to the provision of outpatient services is having a very definite effect on the care provided to the public. It is helping to relieve the strain on in-patient facilities. This will be better understood when it is pointed out that, under the Plan in Nova Scotia, a service was provided within 48 hours of any accident, that included all emergency diagnosis and treatment, all necessary laboratory and x-ray procedures, operating room services, if required, all routine surgical supplies, all drugs and necessary blood supplies. In addition to these emergency services, the Plan offers a long list of free laboratory examinations, E.E.G., diagnostic procedures using radioisotopes, radiotherapy for malignancy, most services of the Nova Scotia Tumor Clinic, blood and hospital services in connection with a long and comprehensive list of minor medical and surgical services.

Since its inception the Commission has approved the construction of facilities for 1600 beds. There are now about 3400 beds in the province's general hospitals. Thus it is obvious that we are about to see a tremendous increase in patient care through the provision of this extra accommodation.

Is the patient load going to increase? Experience to date shows that the patient census is up. Moreover it may be expected to increase, both on the basis of a higher occupancy rate and on the basis of more beds being available in the future as hospitals are enlarged.

In considering the patient load, it is important to give some consideration to the average length of stay. In the first months of the Plan, this tended to decrease. This was occasioned by a relative lack of beds, and by more people going to hospital. The end result was a more rapid turnover. As

The Honorable Mr. Donahoe is the Minister of Public Health for the province of Nova Scotia. He gave this address at the biennial meeting of the Canadian Nurses' Association in 1960.

more beds become available, the length of stay almost surely will return to a more average level. With proper standards of control, the length of stay should be within normal limits. There is no reason for it to be excessive.

Of course, the long-stay, active-treatment patient does present a different picture, not only in terms of numbers but also in terms of length of stay. With the advent of expanded regional hospitals that will provide rehabilitation facilities for long-term patients, it is only logical to expect that we will have more of these patients in our regional hospitals. This is very desirable since the newer methods of rehabilitation have shown that we can restore these people to a large measure of health. From a humanitarian and even an economic viewpoint, it is better to have the patients who can be rehabilitated, in hospital rather than having them stay idly and often hopelessly at home.

It may be said in summary then that in the near future we will be having a significant increase in the number of hospital patients; that the length of patient stay will remain at approximately average level; that, as rehabilitation facilities are established in our regional hospitals, there will be a major increase in the number of long-term, active-treatment patients who are being rehabilitated. The provision of adequate funds for operating expenses has meant that pathological, radiological, laboratory and all other services which contribute to patient care are being provided on a more generous scale with steady improvement in standards of care.

From the nurses' point of view interest lies mainly in the effect that the hospitalization plan will have on the nursing component of patient care.

It is noteworthy, and indeed of great importance, that the nursing profession has played a part both in the development of the hospital insurance plan in this province and subsequently in the operation of it. The Hospital Services Planning Commission included a nurse among the five members. The nursing profession was also represented on the Advisory Committee to the Hospital Services Planning Commission. Later, when the Plan came into effect, there was a nurse member on the Hospital Insurance Commission. In addition, in this province the Advisory Committee of the Registered Nurses' Association of Nova Scotia is one of the three important and major advisory groups to the Commission. The other two represent the Hospital Association and the medical profession. The Professional Technical Advisory Committee to the Commission, the Committee to which matters of a professional or technical nature are referred, has a nurse member. There is also a subcommittee of the Commission made up of the nurse member of the Commission, the nursing counsellor to the Commission, the nursing consultant to the Commission and the consultant in hospital administration who is also a nurse. The Commission has a nursing counsellor on staff who advises and assists the hospital in matters related to nursing services. From the foregoing, it is evident that the nursing profession has played and is playing an important role in the administration of the hospital insurance plan in Nova Scotia.

The nursing profession is justly exercised about the maintenance of a high quality of care for patients. I do not think that after a year and a half of operation of the Hospial Insurance Plan in this province, there is any doubt in the mind of any nurse regarding the attitude of the Commission. We have made it abundantly clear that our prime concern is the maintenance and development of a high standard of patient care. We feel that with our Advisory Committee, consultants and counsellors, we are well informed of professional opinion in regard to pertinent nursing matters. We have encouraged the employment of qualified personnel, allowing additional remuneration for such personnel. We have worked closely with the Department of Public Health in securing bursaries for postgraduate training. In essence, we have attempted to ensure that there was not only a well-qualified staff, but also an adequate staff. In the matter of equipment, the Commission has granted every reasonable request. It has undertaken to make specific enquiries in regard to such newer concepts as intensive care. In other words, the Commission does not wish to maintain the *status*

quo. It wants to see inaugurated any new procedure or program which will provide a better standard of care for the patient.

Early in the course of the Plan, there was some doubt as to the status of schools of nursing. It was very quickly made clear that the Commission wished to see the development and proper support of schools for nurses. Many of you know that the Commission of this province has done everything possible to encourage the employment of qualified instructors and other necessary personnel. Amounts in budgets related to nursing schools have always been given the most sympathetic consideration.

In Nova Scotia, as in other provinces, there has been one difficult area: "The interpretation of necessary nursing services." The principle upon which the Commission operates is that for *any* nursing service in or at a hospital to be an *insured* service, it must be provided to an entitled resident; be provided by the nursing staff of the hospital; be medically necessary. If the service does not meet with all of the above conditions, then it is *not* an insured nursing service.

As it has been many times stated, "private nursing" or "special nursing" is *not* an insured service. Subject to the policy of the hospital, a private nurse may be engaged by or on behalf of the patient. Actually, the procedure within the hospital with respect to this matter is quite a simple one. If the attending physician is of the opinion that it is *medically necessary* for his patient to have nursing services above the average level provided by the hospital, then he should make known and discuss these needs with the director of nurses. It must be understood that the decision as to how the augmented nursing services are to be provided to the patient is the responsibility of the director of nurses. She may see fit to reallocate existing staff or if her staff is temporarily inadequate, she may engage and pay a temporary staff nurse. The staff nurse should be assigned to duties that will permit the most effective use of her services. It well may be that the hospital authorities may designate an area or areas of the hospital in which such augmented nursing services may be provided; for example, the intensive care unit.

As all hospital authorities know, we have attempted in Nova Scotia to place the maximum authority (and consequently the responsibility) for the control of standards at the hospital level. We think this is the sound and common sense way to operate. One of the responsibilities of the Hospital Standards Committee is to study and advise the hospital board on the utilization of nursing services. All cases in which unusual nursing services are being given or have been rendered should be reviewed by this Committee.

I have tried to touch upon some of the major points in our provincial hospital insurance plan which are of particular significance to you as nurses. I have tried to make it clear that the hospital insurance plan does not represent any radical departure from the past. This is not to say that it does not present certain challenges. I have also attempted to show that the profession has not been left out of either the planning or the actual operation of the Plan; that every effort is being made to ensure that the highest standard of care is developed and maintained.

There are certain difficulties inherent in the provision of nursing services; in the efforts to improve them and to integrate them smoothly with the operation of a hospital plan. However, as long as the nursing profession maintains its high standards and is actuated by the ideal of service, and as long as the Hospital Insurance Commission recognizes and accepts this ideal, then we may have every confidence that the relatively minor adjustments necessary will be made; that standards of patient care will continue to see steady improvement; that the sick and the incapacitated will be the ultimate beneficiaries of the joint efforts of those responsible for a Hospital Insurance Plan and nursing services.

I am not arguing with you — I am telling you. — J. McN. WHISTLER

The Curriculum in Schools of Nursing

SISTER MARION, S.S.M., M.Sc.

A review of how the curriculum can serve to bring about the necessary growth and development of nursing students.

THE CURRICULUM has been commonly defined as "all the experiences that a learner has under the guidance of the school." *(Encyclopedia of Educational Research, 1960 Ed., p. 358)* This is the broad definition and includes not only content but also the process by which students achieve the goals of the educational institution. This definition also includes the student personnel program but for purposes of brevity, we will omit this discussion.

The curriculum is a *means to an end* — it is a tool — an implement, which, in the hands of a master can bring about the fruition of the potentialities possessed by the student nurse so that she can become a Christian woman, a professional nurse, and a productive member of society. Four essential determinants must be considered:

1. *The nature of man* — for our purposes we might consider this to mean the needs of our students. What do they need to function effectively as professional nurses?

2. *The nature of society* — we might consider this to mean the needs of man in health and disease — the maintenance of health, the prevention of disease, and adjustment to illness — as they relate to the individual and to society.

3. *The nature of the school* — which we might consider, as an institution charged with the responsibility of educating nurses which involves a body of knowledge (content) and suitable experiences through which this knowledge might be applied to individuals in health and disease (process).

4. *The nature of learning* — given this set of circumstances (the nature of man, society, and the school) how can we best utilize the findings of psychology to bring about the most necessary, the most certain, the most extensive, and the most enduring knowledge and experience for our students? In working from the simple to the complex, how can the necessary knowledge, skills, and attitudes be organized to allow for the development of the individual? To be specific, how do we determine *levels in nursing?* What are the knowledge, skills, and attitudes necessary for an individual to function as a freshman? a junior? a senior? a graduate? a teacher of nursing? an administrator of nursing service and nursing education?

With these thoughts in mind, let us consider curriculum development.

Determination of Educational Objectives

Basic to all curriculum planning is the determination of educational ends or objectives. Most educators agree that a guiding philosophy is essential to the proper functioning of the school. Despite its necessity, the formulation of objectives is not an end in itself; its purpose is to bring about *better teaching* and *better learning.*

Ideally, curriculum planning is a function of the faculty although the importance of the administrator, the students, and resource personnel cannot be discounted. Although some curricula have been developed by individuals, the force of several minds and many ideas working for the accomplishment of a common goal seems to aid in the development of a more acceptable and more complete program.

The determination of educational objectives by a faculty group can take place in several ways. One method is to begin with a discussion of basic principles and then apply these principles to the school situation. It has the advantage of beginning at the beginning, but some consider it lacking in interest for the initial step in the curriculum development.

A second way, the most frequently used procedure, is to merely have the group prepare a statement of objectives. This method may fail to relate

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the objectives to the realities of school and school life.

Another method is to accept a list of rather broad purposes of the school and to analyze one or several in relation to actual school problems. Its advantage lies in a direct attack upon the school problem; its weakness is the consideration of the problem before certain basic principles are agreed upon.

A fourth approach is to begin with an outstanding problem in the school or community which eventually must lead to a discussion of the purpose of education. This method provides motivation and interest in discussion but ultimately leads to using the first method.

Whatever the method used for determining educational objectives, those ultimately set forth will be a reflection of the group's philosophy of life. The method seems not as important as the *end result;* the method may be somewhat determined by the character of the group. Depending upon how the group views man, society, the school, and learning, the resultant objectives will be a mirror of those views.

Patterns of Curriculum Organization

The two polar types of curriculum organization are the subject-centered and the student-centered curricula. The subject-centered curriculum is organized logically rather than psychologically, for the purpose of explaining, not for discovering. Learning activities take place within the organized system of the subject. The major emphasis in this method is explanation — lecture, discussion, question and answer, oral and written examinations. The subjects are either required or elective and the class periods are of definite length. Extracurricular activities are more isolated.

In the activity or experience-centered curriculum, the content and structure is determined by student interest and felt needs. The common learnings come from common interests. Activities are planned cooperatively by the teacher and students. Problem solving is the dominant method, not explaining. Activities are part of the regular curriculum. There is flexibility in rooms, time, and grades. In contrast to nurses being educated in subject matter areas, they are broadly educated with specialized work in developmental psychology and guidance.

Curriculum groups must determine whether organization will be based on the patterns of human knowledge or around the problems and needs of, for example, patients. The former may consist of subjects in the narrow sense of the term, or may be combinations of narrow patterns (broadfield and fusion). The latter may be organized as a core program or more radically, as the experience curriculum. There should be both horizontal and vertical development.

Repardless of the type of organization used, it should be an expression of ways to attain he educational objectives previously set forth.

The Scope of the Curriculum

Scope may be broadly defined as the content or the breadth of the curriculum. It includes the important areas or divisions of the subject. Quite simply, it might be called the "what" of the curriculum. Depending upon the educational objectives and the pattern of curriculum organization, scope may be defined as the essential subject matter, areas of problems and basic social functions, or a combination of these.

Sequence of the Curriculum

Sequence takes up the question of the placement of curriculum materials from the time standpoint. The sequence may be spoken of as the "when" of the curriculum. It may be defined in terms of objectives characteristic of each level, rather than in terms of overall themes, or centres of interest. In the subject field the sequence may be determined by the growth patterns of the student. It also may be determined by interest patterns or developmental tasks, and sometimes by levels of difficulty. The easiest way to arrive at a sequence is to adopt, in modified form, the sequence prevailing in other schools. Sequence becomes a means of carrying out the educational philosophy involved in the scope.

Preparation of the Courses of Study

The course of study is the instrument designed to guide the teacher

in selecting and arranging the elements of the curriculum so that the student's experience with various aspects of the school environment will result in desirable learning. It is intended to assist the teacher in the effective use of the curriculum to achieve the desired outcomes of education. In adapting a course of study to meet the needs of a particular group of students, the following steps are suggested:

1. Obtain pertinent, first-hand information in regard to the students and the social scene of which they are a part.
2. Supplement this information with data from secondary sources.
3. Consider which educational needs are met by outside agencies and other school courses.
4. On the basis of the distinctive contribution which the course can make to the needs of students, which are not served by other agencies or school courses, formulate a set of specific objectives for the course.
5. Establish the validity of the objectives of the course by relating them to the educational philosophy of the school as expressed in the official course of study.
6. Make an inventory of possible effective activities and learning materials coming within the scope of the course to ascertain the degree to which they contribute to the stated objectives of the course.
7. Consider what modifications are necessary because of limitations of time, equipment, and building facilities.
8. Take into account the requirements of accrediting agencies, colleges, local school authorities, and provincial law.
9. Review the level of activities and learning exercises suggested in the official course of study.
10. Organize the content into units of instruction.
11. Make a tentative time allotment to each unit on the basis of its relative significance in achieving the objectives of the course.
12. Select from the teaching procedures suggested in the official course of study, those which appear to be best adapted to the students concerned.
13. Evaluate outcomes in terms of the stated objectives.
14. On the basis of the results achieved, make a tentative revision of the course of study.

Preparation of the Resource Unit

Resource units provide the materials from which teaching units can be made. A resource unit is a compendium of suggested activities and materials used by teachers in their preparation for teacher-student planning of learning experiences. Resource units provide the vehicle by means of which teachers can begin applying curriculum principles in the instructional program. They should be consistent with the general objectives of the school, and with the frameworks established in the subject fields and in the core curriculum, or common learnings.

The following suggestions are offered for the use of resource units:

1. Read through carefully the significance of the area and the outline of the area.
2. Plan a teaching unit so that it is built around some problem appropriate to the stage of development and needs of the students.
3. Set up the specific objectives and generalizations for the teaching unit.
4. Study every possible approach and select the proper one to open up real possibilities for a problem.
5. Collect the materials needed for your approach or make the necessary contacts. This is where clinical experience begins and is justifiable only when it is a proper learning experience to the student.
6. Collect the reading materials needed and become thoroughly familiar with the subject matter they contain.
7. Compile a list of the materials available to the students and post it on the bulletin board when needed.
8. The next step should be that of actual teacher-student planning of the solution of a problem that has been made meaningful to the student because of the approach.

Preparation of the Unit of Work

The teaching unit is a specific lesson plan. It contains detailed statements of what the teacher and the students will do. It could contain a list of questions which the teacher would use to guide student discussion. It would contain leads to further activities such as field trips or library work. It is an advance guide to the teacher's and students' activities. A teaching unit may be prepared by one teacher for another

teacher or a group of teachers. They may be written up as a formal lesson plan, or merely be jotted down on note paper.

The materials for a teaching unit may come from a number of sources. It may be a memory of materials and activities she has used in the past; she may ask other teachers for suggestions; she may consult textbooks; or she may go to a resource unit.

Development of the Learning Experience

If the Morrison plan is adapted to the teacher's own instructional purposes, it serves as a method for developing, psychologically, the learning experience. The objectives and activities in each of the five steps of the "pal plan" as suggested by Morrison are as follows:

1. *Exploration:* The teacher ascertains what knowledge the students already possess in regard to material included in the unit and what misinformation and erroneous concepts they have about it. The means is by a pretest to save time, establish an apperceptive sequence, and orientation.

2. *Presentation:* The teacher presents a brief overview of the unit in which she indicates the chief features of the unit, with particular reference to its purpose, general content, and significance. The purpose is to arouse interest, to provide for motivation, and to enable the student to assimilate the unit in an effective manner. This is followed by a test to ascertain the degree to which the students grasped the central idea. It may be necessary to present a second overview of the unit.

3. *Assimilation:* A long, directed study period is next engaged in under the direction of the teacher. Students utilize clinical experience, books, library references, audio-visual aids and field trips to obtain pertinent information. The teacher checks on student progress by means of progress tests and also individual and group conferences.

4. *Organization:* The students next organize the information they have obtained for presentation to the group. It may be in the form of notes for an oral report, for a debate, seminar, or panel discussion, or a written report. This serves as an aid to further mastery of materials, as well as serving as the basis for the activities of the recitation period.

5. *Recitation:* The student presents the results of her study to the group and teacher. Each student is responsible for contributing to the total knowledge and understanding of the group.

The development of the learning experience is dependent upon the students and the teacher as well. Such factors as: activity, use, frequency, exercises, repetition, association, satisfaction or annoyance, readiness, interest, effort, attention, intensity, and motivation play varied and varying parts in the learning process. It is wiser to use common sense than depend upon any one or set of rules.

The area of clinical experience may cause many difficulties and frustrations. Essentially, this clinical experience is the laboratory in which knowledge becomes meaningful, skills are developed, and attitudes are formed. Instead of test tube or microscope, instead of the Benedict test or a slide of Hemophilus *pertussis*, the student has patients with a variety of diseases and endless behavioral responses to illness. Some curricular patterns are based upon the normal growth and development of an individual from conception through senescence. Thus the student is exposed first to the normal individual. Using these norms, the individual in illness is considered from all aspects but always thinking in terms of the return to normal, at least as far as is possible for this individual.

Whatever approach is used, learning experiences should be selected to:

1. Give the student an opportunity to deal with the content, develop the skills, and secure attitudes implied by the objectives previously determined.

2. Allow for a reasonable amount of satisfaction by the student in being able to achieve these objectives.

3. Maintain the experiences within the range of possibilities for the student, recognizing that many kinds of experiences may attain the same objective.

4. Economize on time by avoiding unnecessary repetition and by achieving the greatest number of objectives through the least possible number of experiences.

In general, we might say that clinical experiences should be selected so that

they are necessary, meaningful, intimately related to the objectives proposed, realistic, and normally innocuous to the patient, other personnel, the student, or the institution.

The curriculum is most important to the learning process and to the school. But the teacher, to my mind, is still the touchstone of success or failure of students. The happiness derived from leading others to truth and enlightenment cannot be adequately expressed — except that it pervades and defeats physical exhaustion from long hours and inadequate facilities, and overcomes mental strain from attempting to help the students realize their potentialities.

A Conference on the PILOT PROJECT FINDINGS

THE presentation of the Report on the Pilot Project at the biennial meeting of the Canadian Nurses' Association marked the completion of the first main step towards accreditation of schools of nursing in Canada. The findings of that study, as set forth in the Report, indicated how much remains to be done before the objective can be reached. It was a rude awakening to find that only four of the 25 schools studied would have been eligible for accreditation had such a program been in effect. The report recommended among other steps, a re-examination of the whole field of nursing education, and a school improvement program to assist in upgrading our present patterns of nurse education. The latter implies that each school of nursing must look critically and honestly at its own program to see where the strengths and weaknesses lie. There will be no room for complacency with the *status quo* nor should there be any room for a "put it off till tomorrow" attitude.

The members of the Canadian Conference of Catholic Schools of Nursing, which is a permanent committee of the Catholic Hospital Association, have begun that self-examination. In preparation for the meeting held at St. Joseph's Hospital, Toronto, January 23-27, 1961, the various areas of the Report were assigned to groups across the country for intensive study. A summary of the project findings in each area was prepared and the implications for Catholic schools of nursing indicated. These reports were presented by members of the various study groups to the conference. SISTER DENISE LEFEBVRE who, as chairman of the CNA Task Committee, member of the liaison committee and senior bilingual evaluator, had contributed so outstandingly to the Pilot Project, was the moderator for the week's program. SISTER MARY FELICITAS, chairman of the C.C.C.S.N., set the tone of the deliberations in her opening remarks when she noted that this was a decisive hour in the history of Canadian nursing as the planning for a "superhighway" for nursing education begins.

Philosophy and Objectives

Following a review by Sister Lefebvre of the steps leading to the initiation of the Pilot Project and the details involved in implementing it, the first main area of study — the philosophy and objectives of schools of nursing — came under scrutiny.. SISTER MARGARET MOONEY's review of the findings of the Pilot Project showed this to be an area of general weakness. Seventeen of the 25 schools did not define nursing in their statements. Many schools could not even find a formulated philosophy in their files; others felt that the statements on hand were much in need of revision. In several instances, statements of philosophy and objectives were formulated so that the questionnaire could be answered.

Sister Mooney emphasized the need for building a philosophy, by looking beneath general principles and finding out what producing a good nurse really

means. The criteria for evaluation of philosophy and objectives as used in the Pilot Project were considered valid and acceptable. Individual schools would differ in their philosophy to some extent but, as long as an accreditation program took this into consideration there was no need for concern.

REV. G. E. CARTER, St. Joseph's Teachers College, Montreal, commented on the primacy of aims.

Unless aims are kept in view, the program as a whole will not be coordinated. Schools of nursing have failed to follow through in the level of the educational programs offered. Entrance requirements are sufficiently high to warrant programs of college calibre.

In a serious consideration of philosophy and objectives, the *concept of the total person* must be incorporated. Are we going to produce nurses who are simply skilful technicians or do we want fully developed human beings and leaders? The answer lies with the schools of nursing. What is the aim of the school — to prepare nurses or to provide cheap nursing service? This question, too, must be answered.

The average nurse is not given a broad enough educational background, although nursing tends to be somewhat better about this than the other professions. The nurse must be prepared as a *leader in her own milieu*. To fill this role she requires a sufficiently broad preparation to permit her to see the intellectual side of nursing. It was suggested that students should receive, as part of their preparation, a basic course in philosophy presented as problems in living which they would be helped to solve.

Professional ethics must be held high but should include positive as well as negative aspects. Too often we tell students what they *may not* do and forget to indicate what they *may* do.

Nurses possess a certain power by virtue of their femininity. Their profession should never make them "hard." However, they need a concept of the conduct of life as a woman to help them retain and develop their womanliness.

Who should phrase the philosophy of the school? The entire faculty should be involved, if at all possible. They are the people who will implement it. They must understand it thoroughly and not feel that the philosophy has been arbitrarily superimposed. Increasing the number of those involved in policy-making may create problems but, on the positive side, there will be wider understanding.

The philosophy and objectives must be made known to new staff members and students.

The objectives of the curriculum must fit into the pattern of the general philosophy. There should be clear justification for the inclusion of each specific subject within the curriculum. The student must always be able to see *why* she is learning this or doing that. This spells the difference between preparing a good practitioner and a true nurse.

Organization and Administration

Various aspects of this area, as related to the school of nursing, were reviewed and discussed. It was suggested that there should be a distinct division between the administration of nursing service and nursing education. There is extreme need for cooperation between the two entities. There must be equally good educational preparation on both sides so that they may appreciate and understand each other's viewpoints.

The aim of the school of nursing is to prepare universally acceptable nurses; the aim of the hospital is the care of the patient. The student nurse really puts herself into the hands of the faculty and looks to its members to guide her in her total development as a nurse and a person. How well this responsibility is met will determine the extent to which the aim of the school is achieved. The school should have total responsibility for the student; her welfare must be its main consideration.

Generally speaking, communication between nursing service and nursing education is deficient. The two should unite for curriculum planning. There is a lack of faculty organization. There is need for general clarification of roles.

In budget preparation, each department should see where it fits into the total picture. When the faculty is given a part in the planning, personal interest is greater.

An advisory committee to the school of nursing, if carefully selected, can be very helpful. The director of nursing should have the freedom to select this committee. It must be truly advisory

in nature and meet frequently enough to be helpful.

The control of the school of nursing may present some problems. It is in a unique position in that it is an educational institution attached, in most instances, to an essentially non-educational body (the hospital). This makes it rather difficult to justify our use of the term "professional" in reference to nursing.

Canadian nurses must take the initiative in deciding where control will lie. Schools of nursing under university egis would appear, on the surface, very desirable. But universities tend to have little consideration for schools with a practical side. What might happen to present curricula? Would there be adjustment in university courses to meet the needs of nurses? What would happen to the autonomy of the school of nursing?

Library Facilities

In general, the survey visitors found the area of records, reports and announcements was reasonably adequately covered by the schools. Unfortunately, school of nursing libraries left much to be desired. SISTER FRANCIS DE SALES, St. Michael's Hospital, Toronto noted that library facilities constitute a predominant area of weakness. Sixty per cent of the surveyed schools had arrangements with outside libraries to supplement their own facilities. Only *one* school was actually making use of associated resources. How honest is this? The nurse, student or graduate, needs the library if she is to develop a taste for reading and research. She needs the services of a qualified librarian to guide her and she must be assured that the library will be open during her free time. The "locked library" deprives the individual of the chance to study and is a source of gross frustration to the better students.

Miss MARY SHAVER, St. Michael's Hospital, Toronto presented a very interesting paper on a suggested pattern for library facilities and the part that the library plays in the life of the nurse. It will appear in the *Journal*.

SISTER MARY CAMILLA, librarian of St. Joseph's School, Toronto suggested that there is a moral as well as an educational obligation to provide the texts necessary to help students attain their goals. She noted that in the USSR, the *law* requires that every school have a library with a fully qualified librarian. The following points, extracted from her address, may be helpful:

1. The library should be adapted to the kind of institution or segment of society of which it is a part.
2. School of nursing libraries should include fiction and recreational reading.
3. Periodicals are an integral part of any library. By the time information appears in book form it is often out-of date.
4. A short introductory course on library science would be helpful to students. There should be at least a few lectures on the use of the library included in the curriculum.
5. Library seating arrangements should accommodate 15-20 per cent of the student body at any one time. Surroundings should be attractive, comfortable, inviting. It should be noted that the librarian's personality can affect the extent to which the library is used.
6. Special displays of book jackets, etc., can motivate the student to read.
7. Individual instructors could have shelves set aside for their special use on which to display the books of current interest to their courses.

The members divided into study groups for a portion of the day's work and concentrated on problems related to the areas already discussed. Summaries of their conclusions were presented.

Preparation of the Teachers

The Pilot Project survey found that one of the most critical situations was the lack of academic preparation among instructors. Opportunities for advanced preparation in Canada beyond the bachelor's level, are as yet almost undeveloped. Young graduates must be encouraged to take advanced preparation in nursing education. SISTER AGNITA CLAIRE, St. Louis University, Missouri, speaking in relation to nursing education in general, raised the following points:

What is expected of the professional nurse? How is she prepared to meet these expectations? Who decides what quality nursing care is? Have we really defined what type of nurse we want? What are the aims of the average school of nursing?

She suggested that the current nursing crisis might be met by programs of different lengths: Diploma or associate degree for those giving bedside care; baccalaureate degree for the head nurse, public health nurse; master's degree for the person in teaching or administration. The ANA has recommended that the baccalaureate degree should be the minimum requirement for the professional nurse with the associate degree or diploma being at the technical level.

Prospective student nurses with special ability should be directed into degree programs from the beginning as a step in speeding up the preparation of teaching staff. Those holding diplomas should be encouraged to take advanced preparation. There should be a definite plan in relation to unqualified personnel, to have them continue with further study.

To try to reduce the present turnover in staff, we should question whether or not teaching positions are being made sufficiently attractive in respect to salaries and good personnel policies to draw good teachers and to keep them contented.

The employment of part-time instructors is educationally unsound. They do not see the whole picture of the curriculum and continuity may be lacking.

The doctor lecturer has a very definite contribution to make to the teaching program in a school of nursing but should not be made responsible for a course. He can be given a specific assignment within a course.

In the area of curriculum, Canadian schools of nursing can, with considerable profit, do much towards improving their use of this "tool" in achieving their prime aim — the preparation of nurses. SISTER MARION, acting director, Department of Nursing Education, St. Louis University, presented her views on this topic in an article appearing in this issue.

Quality in the Clinical Field

A further recommendation of the Report of the Pilot Project indicated the need for a survey of the quality of nursing service in the clinical areas where students receive their experience. This would seem to intimate that the setting for our educational programs leaves something to be desired.

SISTER LAURETTE DE LA STE FACE, Hôpital Ste Justine, Montreal reviewed the survey results and SISTER HÉLÈNE DE MARIE IMMACULATE from the same hospital commented on the present seeming inability of schools to meet criteria and what remedial steps might be taken.

Sister Agnita Claire spoke of the difficulty in defining what adequate clinical experience really is. The following comments are extracted from her address on clinical facilities:

No hospital should attempt to carry on a school of nursing *unless it has sufficient staff for nursing service.*

Good nursing education cannot take place in a climate of poor nursing service. Students must see principles practised.

There should be a separation of nursing service from nursing education. The director in a dual role as head of both can hardly help but suffer a "split personality." The educator's first responsibility is the student nurse.

The hospital should not finance the student. She should pay her tuition, room and board.

The resources of a hospital must be analyzed to see how many students can be accommodated. There must be a sufficient number of patients representing various disease entities to provide adequate experience. This does not mean that the student needs to care for patients with every disease listed in the medical text.

Present emphasis is on *comprehensive nursing care* and should include teaching, understanding and managing patients.

Evaluation

The evaluation of students and the educational program should be directed towards determining whether or not school objectives are being achieved. Survey visitors found that 76 per cent of the 25 schools gave evidence of a satisfactory plan for assessing student performance throughout the entire course. Self-evaluation was not used as extensively as might have been expected—about 52 per cent of schools had this plan. Evaluation of the educational program and its curriculum appeared to be carried out informally and without any definite time plan.

The discussion that followed the review of this area included the following points:

In spite of the current trend towards objective tests, subjective tests have considerable value in that the student learns how to organize material.

To avoid ambiguity in test questions, instructors should have other faculty members take the test or check the questions, discarding any questions that are not clear.

Examination papers should be returned to the students so that they may see what they have done correctly or incorrectly. Instructors may collect the papers again.

How can the growth of the nurse as a woman and a person be evaluated? Knowledge, skills, attitudes can be fairly easily assessed. Apart from that, careful observations of the student, and giving her a chance to express her opinion of her own performance can help in total evaluation.

One of the conference experts was very much opposed to the use of anecdotal records. There is too great a possibility that one mistake could be held against the student indefinitely.

Can nursing service personnel evaluate the student? Generally speaking, the evaluation from this service should be accepted with reservations since emotional factors may be involved.

It was suggested that graduates of a school should be asked to evaluate the program anonymously over a period of years. It would provide an opportunity to see where the program has been a success or a failure.

If there are too many "problem students" it would be wise to look for problems among the staff. Problems can be used as a means for personal growth and every possible effort should be directed towards that end rather than trying to get rid of the student.

Why are we making out evaluation reports? It gives the student a chance to see how she is doing. Strengths, as well as weaknesses, should be brought out. The discussion of the report with the student provides a point of contact between her and the director of nursing and the opportunity for each to know the other better. Students need to be reminded of the fact that they are human and will do better in some areas than in others.

If evaluation reports were made out at intervals during the student's experience in a unit, rather than just at the end, she could see her strengths and weaknesses early enough to try to correct the latter. The final report then gives her a chance to see how far she has come.

Student Personnel Services

The final session was based on student selection, organization, counselling, health services, etc.

It was considered important that contacts with high schools, particularly through the counselling staff, should be intensified so that the right people can be directed into nursing.

A selections committee to determine admissions to the school might reduce the attrition rate.

Student organizations provide experience in becoming self-directive. It was suggested that students, in many instances, could be allowed more voice in residence regulations, punishment of infractions, changing rules.

The pros and cons of residence life were touched upon briefly. "Living-in" provides experience in cooperative living, in discipline, in developing good standards of hygiene and of study habits. "Living-out" perhaps has certain benefits but do these outweigh residence life? Should the whole question of residence living be reconsidered?

In considering financial assistance to students, the possibility of a loan fund from which students who were doing well can borrow was suggested. It should be administered in a businesslike way with appropriate legal documents.

Apropos of a monthly stipend, is this simply a matter of paying students to accept mediocre education?

Sister Marion, St. Louis University, as the expert on counselling programs, included the following points in her address on this aspect:

Guidance and counselling should be a continuous process, not just a supplement or a complement to the student program. Rather it should be a "completement."

The underlying philosophy must be based on sincere love of people and should incorporate a belief in individual differences and the fact that every one has a contribution to make.

Counselling should start *before* the student enters the school, during the recruitment period. Counselling personnel should be represented on the admissions

committee. Some type of pretesting service should be utilized. The NLN battery of pretests has been proven effective.

Counselling personnel should assume responsibility for the new student's orientation.

Counselling should cover all aspects of student life — academic as well as personal.

A guidance service requires organization and administration. It must be a service that is both wanted and needed. Lines of authority must be carefully delineated to prevent conflicts between the counsellor and the director of nursing, the counsellor and others on the staff.

Student records are important but one must use prudence in respect to what is put on the permanent record. Many employers may lack understanding of such matters as mental illness, for example.

Students must be assured of privacy for such interviews and must be equally certain that what they have to say is held in complete confidence.

The director of nursing should be able to trust the counsellor to come to her or direct the student to her as the occasion requires.

The counselling program requires research to determine its strengths and weaknesses and revision as necessary.

As reference material in counselling, the following texts were among those recommended:

1. Personnel Program Guide, Johnston. Philadelphia: W. B. Saunders Company.
2. It's Your Personality, McMahon, Cribbin and Harris. New York: Harcourt Brace.
3. Personal Adjustment and Mental Health, Schneider. New York: Reinhardt.

Epilogue

The conference members went home with a definite assignment. The various schools will begin work very shortly on the questionnaire answered by the schools surveyed during the Pilot Project. The completed forms will be submitted to the Catholic Hospital Association for study. Having answered the questionnaire, the individual school will then be in a position to assess its own strengths and weaknesses and to institute changes as necessary. Such a step will be very much in accord with the follow-up program to the Pilot Project which calls for school improvement measures.

On the lighter side, this report would be incomplete without mention of the gracious hospitality of the Sisters of St. Joseph Hospital which included a delicious banquet on the Tuesday evening; the Wednesday evening program with Sister Denise Lefebvre as the very much surprised but delighted recipient of an address and gift; the efficient work of the translators who contributed so much to the smooth functioning of the conference.

The value of such a conference required no clearer testimony than the request that the meetings should be held on an annual basis. Appreciation for the opportunity to study together this question of accreditation and to benefit from combined thinking was expressed on every side.

JEAN E. MACGREGOR

A Memorial Library

In tribute to the late AGNES J. MACLEOD, memorial items have been presented to the University of Alberta Hospital. These items include an oil painting of Miss Macleod, a scroll and a framed display of her service decorations and medals. She was a member of the first class to graduate from University Hospital and she became the first director of the graduate school of nursing at the University of Alberta. The student nurses' association has received the name of the Macleod Club and the library in the nurses' residence is now known as the Agnes J. Macleod Memorial Library.

* * *

Spring rides no horses down the hill,
But comes on foot, a goose-girl still
And all the lovliest things there be
Come simply so, it seems to me.

EDNA ST. VINCENT MILLAY

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

ICN, Melbourne

The outstanding event in the world of nursing during April is the visit of sixty Canadian nurses to the 12th Congress of the ICN in Australia. We have no doubt that the Congress will be of inestimable value to the future of nursing. The many opportunities for professional and social contact will allow for a liberal exchange of ideas and opinions.

Our President, Miss Helen Carpenter will extend an invitation to ICN to hold the 13th Congress in Canada. We are eagerly hoping that Canada's invitation will be accepted.

ICN Exchange of Privileges

National Office welcomes any inquiries or requests from nurses interested in the ICN Exchange of Privileges Program. Nurses are assured of a warm welcome and the full cooperation of member associations of ICN.

The Exchange of Privileges program was established by the ICN for its member countries for the benefit of those nurses who are members of their national association. The purpose is to provide an opportunity for nurses to obtain: professional study programs, specific nursing experience, or employment outside their own country. Providing her references ensure the suitability of a nurse to represent her country, she is recommended by her national association and is entitled to receive assistance from the national association of the country to which she is going.

In 1960, observational study programs were planned and conducted in Canada for 22 nurses from nine countries. Four Canadian nurses received the same assistance in four countries. During the post-convention European tour, an 8-day program of professional observation was arranged for 26 nurses in four countries.

Last year, arrangements were also made for 45 nurses from 11 countries to have nursing experience and employment in Canada while 25 Canadian nurses benefited from the Exchange of Privileges program in eight countries.

The CNA wishes to take this opportunity to pass on the gratitude and expressions of appreciation of all Canadian nurses who participated in this program to the various associations and health agencies who have planned such interesting and varied programs.

Nursing in Africa

"There are no Congolese nurses in Africa." This is the message we received in National Office from Miss Elizabeth Hill, Public Health Nursing Administrator, Nursing Section, WHO Headquarters, Geneva during her recent visit to Ottawa. Miss Hill also pointed out the lack of doctors and other professionals in the Congo.

WHO has vacancies for 35 qualified nurses. Twenty-three nurses are needed in Africa. Special funds have been made available to WHO by the United Nations for this recruitment.

Nurses interested in WHO assignments often ask what languages are required. English is the most usual, Spanish or French is needed in many countries. At present 175 nurses from 14 countries are serving on WHO assignments. Most of these nurses are from Great Britain, the United States and Canada.

It is difficult to recruit French nurses for these assignments, because they are providing essential service in their home countries and cannot be released for international work. Canada is in a more fortunate position in this respect. Although every country has a scarcity of nursing leaders, Canada has a good quota among both the French and English speaking nurses. We are sure that there are many nurses who are able and ready to make their professional and personal contribution to international nursing.

Miss Hill pointed out that it has been proven that a well-qualified nurse-teacher with a good academic background in the French language can, by undertaking a 3-months' intensive study of French, become fluent in the language.

If you are interested in working with the WHO in Africa, write to Miss Lyle Creelman, Chief, Nursing Section, WHO Headquarters, Palais des Nations, Geneva, Switzerland.

Canadian Nurse Author

All too seldom do we hear that a Canadian has written a book on nursing for Canadians. MARGARET G. MCPHEDRAN, R.N., M.A., well known as a member of the nursing faculty at the University of New Brunswick, is to be commended for her book *The Maternity Cycle* which has recently been published by The Macmillan Company of Canada Limited.

CNA Retirement Plan

What are your plans for the future? Possibly you are thinking of purchasing a home. On the other hand you may be thinking of a trip abroad. Whatever your plans are, money is involved. Are you saving for the future?

Plan A of the CNARP was designed for the individual nurse and much thought has gone into the preparation of YOUR PLAN. This plan is similar to that adopted by the Canadian Medical Association.

Whatever your plans are, we at National Office would like to help you plan for your future. This Pension Plan may be what you are looking for. When you arrange your savings through CNARP your investment is earning money for you. Your local office of the National Life Assurance Company of Canada would like to discuss this plan with you, at your convenience; or write to us at the

Canadian Nurses' Association,
74 Stanley Avenue, Ottawa.

In the Good Old Days

(*The Canadian Nurse* — APRIL 1921)

Speaking of influences that have made for world progress, we are reminded that *woman* in working for the emancipation of others has herself been emancipated, of which her enfranchisement is a tangible evidence, also her admittance, on equal terms with men, into almost every walk in life, educationally, professionally, and of the business world.

* * *

Extending Life — J. S. Huxley, of Oxford, has stated that a considerable measure of control over the life-cycle of a great many animals, and also of man, will be obtained. Experiments have shown that it is possible to modify the rate of growth and the length of the period of growth, and thus prolong life. A worm has been kept at the same age (that is, in the same lively activity), while the rest of the brood passed through nineteen generations. This period, if translated into human terms, would take us back to Chaucer.

* * *

There are 200 Chinese girl students in Paris, who have been sent to study there by the Peking Government. There are four girl students in London, the daughters of wealthy Chinese, studying at different schools. One is at the Royal Academy of Music; she intends to return to China when her education is completed. Another is studying drawing.

Some people are no good at counting calories and they have the figures to prove it.

NURSING PROFILES

Victoria Louisa Protti has been appointed director of outpost hospitals, B.C. division, Canadian Red Cross Society. She is also a caseworker with the provincial division of the Junior Red Cross.

(Williams Bros.)

VICTORIA PROTTI

A graduate of Edmonton General Hospital, Miss Protti obtained a certificate in teaching and supervision from McGill University in 1948. Her experience following graduation was extensive. It included general duty in a number of hospitals in Alberta and British Columbia which was succeeded by a year as matron of a private hospital in New Westminster. Then she returned to Alberta and eventually joined the teaching staff of her home hospital. In 1955, she was appointed assistant director of nursing service, Children's Hospital, Vancouver and served in this capacity until her present appointment became effective.

She has been an interested and active participant in activities of her alumnae association and in the affairs of her provincial association. In addition to housekeeping duties, she enjoys sports and reading. Spare moments are frequently spent visiting the sick and aged.

Elizabeth Josephine Worthy has accepted an appointment as lecturer in nursing at the School of Nursing, University of Saskatchewan, Saskatoon. Born in England and a graduate of King's College Hospital, London and the Royal Liverpool Children's Hospital, Miss Worthy received extensive experience in pediatric care before coming to Canada. For several years she was on the staff of the Hospital for Sick Children, Great Ormond Street as night sister, sister tutor and eventually principal sister tutor. In 1952 she was the recipient of a World Health Organization fellowship in pediatric nursing and came to the School for Graduate Nurses, McGill University. She completed requirements for her bachelor of nursing degree there in 1954.

In 1956 Miss Worthy became a member of the conference group formed by the International Council of Nurses which studied the method of planning nursing studies. In 1957 she returned to McGill University as lecturer in maternal and child health nursing, leaving that position for a year as lecturer in social sciences at the Montreal General Hospital.

ELIZABETH WORTHY

She took an active interest in professional associations in England and for several years was an examiner to the General Nursing Council of England and Wales. Off duty she enjoys art and reading among other pastimes. Best wishes and congratulations are extended to her as she develops her new duties.

The appointment of **Constance Jane Winter** as director of nursing, Westminster Hospital, London, Ontario became effective in February. She had been assistant to the director of nursing services, Department of Veterans Affairs since 1953.

Miss Winter is a graduate of the Royal Victoria Hospital, Montreal. In 1940 she joined the RCAMC and during the succeeding war years, she served in England, Sicily, Italy and Germany. Following her discharge from the army, she was on the staff of Queen Mary Veterans' Hospital, Montreal. Later she became nursing supervisor of the psychiatric division, Ste Anne's Hospital, Ste Anne de Bellevue, P.Q., leaving there to assume her duties with the Department of Veterans' Affairs.

Rosella Cunningham has been appointed director of public health nursing, Metropolitan Windsor Health Unit. A graduate of the University of Toronto School of Nursing, she completed requirements for her B.Sc.N. from the same university in 1950.

Miss Cunningham joined the Victorian Order of Nurses in 1937, serving first as a staff nurse in Windsor and then as nurse-in-charge of the units in Carleton Place and Woodstock, Ontario. In 1944 she joined the Ottawa Board of Education, leaving her post there to become senior nurse with the Northumberland-Durham Health unit where she served for 12 years.

Gertrude M. Hanmer is the new director of nursing for the St. Catharines-Lincoln Health Unit, Ontario. She has been a supervisor in that unit since 1949.

A graduate of the Toronto General Hospital, she obtained her certificates in public health nursing and supervision in public health nursing from the University of Toronto. She also has a bachelor of arts degree from the University of Western Ontario, London. Her nursing experience has included health work at Feller Institute, Grande Ligne, P.Q., general duty at the Grace Dart Hospital, Montreal and staff nursing with the Toronto branch, Victorian Order of Nurses.

Mima Maclaren has retired from active nursing after 43 years in a career that has won her many honors for her services. For the past 12 years she has directed the activities of the 600 members of the nursing staff at Westminster Hospital, London, Ontario.

When World War II began, Miss Maclaren joined the RCAMC and went overseas as sister-in-charge of a casualty clearing station in England. Her war service lasted for five years and during that time she rose through the ranks to become principal matron. In 1944 she received the Associate Royal Red Cross from His Majesty, the late King George VI. When she returned home with the rank of major, the Royal Red Cross was conferred upon her by Earl Alexander of Tunis, Canada's governor-general at that time. She took up her duties as nursing consultant with the Department of Veterans' Affairs, Ottawa and served there until going to Westminster Hospital.

Retirement does not mean that Miss Maclaren will lose her contacts with her profession. She has been appointed as director of volunteers, Ottawa Civic Hospital and, in this capacity, she will continue her interest.

Dorothy Whitcher, who retired from active nursing last year, had served her Alma Mater in various capacities for 24 years. Graduating from Sherbrooke Hospital, Sherbrooke, P.Q. in 1931, she became night supervisor in 1932 and remained in that capacity for the following five years. Private nursing claimed her interest for a few years but then she returned to the staff, first as head nurse in the obstetrical department, then in a supervisory capacity in the nursing school office. During 1951-60 she was in charge of the outpatient department.

DOROTHY WHITCHER

Miss Whitcher is making her home in Rock Island, Que. where she looks forward to having her friends visit her. She will have added opportunity to pursue her hobbies of knitting, needlepoint and cooking.

After 20 years of service to the city of St. Catharines, **Winifred V. Godard** has retired from nursing. A graduate of St. Luke's Hospital, Ottawa, she joined the CAMC in 1915 and spent several years in overseas duty. Following her return to Canada, she obtained her certificate in public health nursing from the University of British Columbia.

An opportunity to visit China presented itself, and Miss Godard joined the staff of the Peking Union Medical College. After several years there, she left China and eventually returned to public health nursing. Her first position in this field was as a member of the outpatient department staff, Englewood, Hospital, New Jersey, U.S.A. where she worked for 11 years. After obtaining her bachelor's degree in nursing education from Teachers College, Columbia University she joined the St. Catharines' city health unit during 1940 as supervisor of nursing. When the St. Catharines-Lincoln Health Unit was organized in 1945, she became its director of nursing.

Her colleagues have paid tribute to her enthusiasm and her unstinted giving of herself in her work. They wish her good health, happiness and success in the years that lie ahead.

PREPAREDNESS PAYS!

ELEANOR JOHNSON

Nursing service at the alert following the explosion in Windsor.

AT APPROXIMATELY 2:15 P.M. Tuesday, October 25, 1960, there was a serious explosion in a Metropolitan Chain Store, three-quarters of a mile from Grace Hospital, Windsor, Ont.

Dr. John McLister, whose office is in a building close to the site, was washing his hands before examining a patient. Through the window he saw a sudden cloud of black smoke, and heard a deafening noise as of "a bomb exploding." After identifying the source of the disturbance he alerted this hospital and left immediately. This doctor is chairman of the Disaster Committee, and prepared our Disaster Plans.

The nursing staff had meanwhile been organized by Mrs. Kearns, assistant director of Nursing Service. The graduate and student nurses already in the operating rooms were assigned to the six theatres, and designated suitable places in the corridor immediately outside the department, where beds and chairs were set up. One graduate was given access to the medicine, and narcotic cupboard. Surgery was cancelled for the next day.

Graduate and student nurses from surgical and medical areas were sent to the emergency room, x-ray, cystoscopy, and physiotherapy to prepare to receive casualties. The switchboard contacted the doctors on the Disaster Roster and requested that they come immediately. The head nurses on the various areas arranged for the discharge of convalescent patients, and prepared to receive casualties according to specifications in the Disaster Plan. The recovery room was prepared for reception of shocked and burned patients, in particular.

By the time the first ambulance arrived at 2:35 P.M. the accounting personnel were organized to identify and transport patients by stretcher and wheelchair. In a short time, two doctors were in place at the admitting entrance to screen and direct. By 3:00 P.M. there were walking casualties in chairs on one side of the main corridor, stretcher casualties on the other side; minor injuries were receiving treatment, and major injuries were in the O.R. or grouped together for intensive care and preparation for surgery; in-patients were ready for discharge; an area on a postpartum floor was being prepared to receive in-patients too ill to be discharged. Nursing office was the press and information centre. By 4:30 P.M. the

Captain Johnson is Director of Nursing, Salvation Army Grace Hospital, Windsor, Ontario.

emergency supply of sterile goods stored in another building was nearly all used, and the local Civil Defence Unit had been asked to bring extra cots.

The hospital treated 60 to 70 casualties of whom 21 were admitted. There seemed to be a minimum of confusion, and a maximum of thoughtful, efficient service. It was necessary to arrange for extra nursing personnel for that evening and night. After that, the regular staff was able to handle the situation.

In the week following the explosion, our problems were mostly related to lawyers, insurance adjusters, press photographers, reporters, fire and police personnel, and official investigators. The casualties were asked for statements, pictures and interviews. It was difficult to protect a patient's welfare without hindering the impartial gathering of vital information.

There are still three patients in this hospital as a result of the explosion. I trust that this account may assist other hospitals to become prepared for any similar event.

Book Reviews

Remember, Nurse by Donalda McKillop Copeland and Eugenie Louise Myles. 250 pages. The Ryerson Press, 299 Queen St. West, Toronto 2B. 1960. Price $4.50.

To most of us the ways of the Eskimo people and the land in which they live remain a bit of a mystery. Few of us have had the opportunity as yet to come to know the Eskimo other than as a patient in our southern hospitals; to see the environment in which he lives out his life; to appreciate the sturdiness of a nature that can withstand the rigors of Arctic life and accept its hardship with patient resignation and good humor.

Southampton Island lies in the broad northern extremity of Hudson Bay. Mrs. Copeland became the island's first public health nurse. Her husband was the first welfare officer, sub-registrar and teacher for the same area. Their small daughter Patsy shared the venture. Mrs. Copeland's story is a warm, human interest one with humor, pathos, tragedy, mystery, success and failure woven throughout it. Through her eyes we see the Eenook in their homes; share her feelings of frustration as her modern medical techniques clashed with the efforts of the local medicine man or the ignorance of the people; discover to our chagrin that women and girl-babies are highly expendable chattels, useful in some instances to pay off bets; share the respect and the affection for the people that she developed as she worked with them.

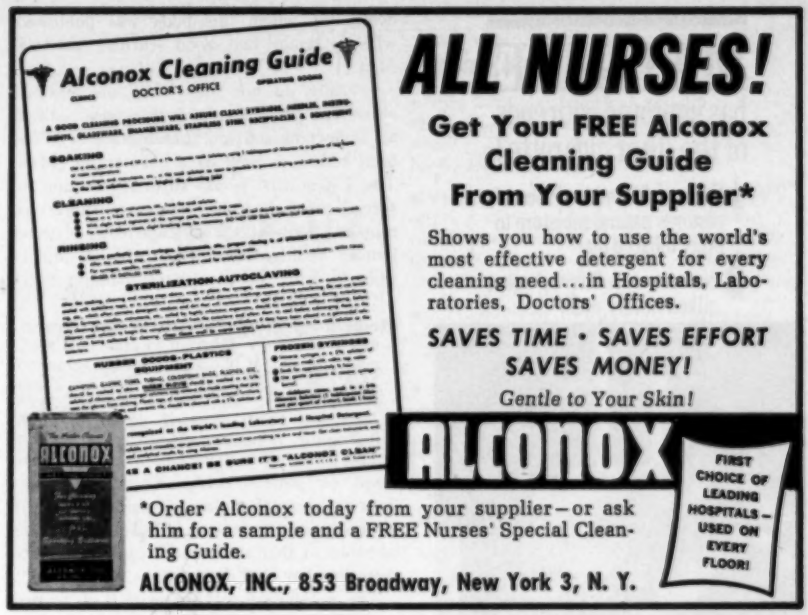
The patient, stoical Eskimo greeted each tragedy that befell him — illness, death, loss of a child, and so forth — with the simple phrase, *Iyonamut* — it can't be helped. The task of its first teacher and its first public health nurse was to try somehow to show that something *could* be done. In small ways the results began to show themselves: The school-children who learned to enjoy their "washing-up" session before classes; the folk who came back from the white man's hospitals cured of their ailments; the steady stream of callers to the nurse's door, day and night, by people slowly beginning to believe that perhaps there was an alternative to *Iyonamut*.

This is a story that any nurse, whatever her particular field of interest or stage of development, can enjoy.

Helping the Elderly to Live at Home. 39 pages. The Central Council for Health Education, Tavistock House North, Tavistock Square, London W.C.1. 1960.

Implicit in the concept of a welfare state is the provision of care from the cradle to the grave. In actual fact, this is a practical impossibility as can be illustrated by the plight of the elderly in Great Britain. There is, at present, an estimated population of about two million people over 75 years of age. Available hospital and welfare home beds total about 136,000. The situation is plain. Many elderly folk in Britain must remain alone in their own homes and become dependent on relatives, friends or neighbors when illness or infirmity becomes a problem.

This little booklet is designed for use by the person who accepts responsibility for an aged individual. The special problems to which the elderly can fall victim are discussed briefly — dietary deficiencies, deaf-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ALCONOX, INC., 853 Broadway, New York 3, N. Y.

ness, poor sight, incontinence, mental confusion, etc. Simple suggestions for prevention, treatment or adjustment are given. It is understood, of course, that medical approval will be sought in all matters requiring diagnosis and treatment. Elderly folk are prone to certain types of home accidents as well. Protective measures are possible. Pride or ignorance can prevent the old person from claiming the state aid to which he is entitled. Interpretation is necessary. The booklet contains a listing of the various available social services.

While interesting, this booklet would have rather limited value for Canadian readers.

The Newly Born Infant by Andrew Bogdan, M.D. 38 pages. Austick's Medical Bookshop, 53 Great George Street, Leeds. 1959.

Reviewed by Miss M. Evans, VON, 1645 West 10th Ave., Vancouver 9.

The author states that this booklet is designed to stimulate the student to further study, and to assist teachers to plan their own lectures.

The text, in note form, gives a minimum of essential descriptive details of the normal neonate: the appearance, reactions and progress. Deviations from the normal and the early signs and symptoms which the nurse should recognize are listed. Suggestions for care until diagnosis is made are included. The standards and preparations used in artificial feeding are British. The methods of resuscitating the newborn, normally performed by the anesthetist in Canadian hospitals, differ.

This text would be useful for the nurse in obstetrics and pediatrics providing it is used as the author suggests, to promote observation during clinical experience; to encourage more extensive reading; to provide a quick reminder of essentials.

Principles and Techniques of Psychiatric Nursing by Madelene Elliott Ingram, R.N. 479 pages. W. B. Saunders Company, West Washington Square, Philadelphia 5. 5th ed. 1960. Price $5.50.

Reviewed by Miss Beatrice Biron, Instructor, Misericordia Hospital, Winnipeg.

The most commendable feature of this book is its comprehensive review questions found at the end of each chapter, and the extensive bibliographies. Mature and more advanced students may find the material elementary. However, the more junior stu-

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dents, for whom this book was published, will no doubt find good learning material in it.

I really do not think that the author's objectives are clear. In this new edition an important subject "Communication" has been added, as well as a chapter on "Man, The Unknown." I was surprised to find no special mention of the important subject of rapport. Without a rich knowledge of good human relationships it is almost impossible to help the psychiatric patient.

Medical-Surgical Workbook for Practical Nurses by Marilyn Gottehrer Freedman, M.A., R.N. and Justine Hannan, M.A., R.N. 150 pages. The Ryerson Press, 299 Queen St. W., Toronto. Price $3.25. *Reviewed by E. Russell, Practical nurse instructor, Winnipeg, Man.*

The book states principles of nursing care based on patient needs. The format outlines or suggests a plan for guiding students in study and note-taking. The pages are detachable so that the student can incorporate them into her own notebook.

The vocabulary and material is in accord with the practical nurse academic level. It is well related to the curriculum and nursing textbooks for this branch of auxiliary personnel. In my opinion, this workbook would be a valuable aid to the instructor in planning and presenting class lectures.

At the present time, I think the price makes it a burdensome addition to the required books for the course. It might also tend to inhibit wide reading by the student in preparation of notes for study. I believe the purchase of a few of the workbooks for the school library would provide guidance for students who need help in learning to compile their own notes.

THIRD WORLD CONGRESS OF PSYCHIATRY

Montreal will be host, June 4-10, 1961, to psychiatrists and members of the allied professions from 70 countries.

Many topics to be discussed will be of interest to nurses; some are as follows: Psychiatric Nursing, Mental Retardation, Child and Family Psychiatry, Therapeutic Community. There is to be a special panel entitled "Nationwide Planning of Psychiatric Services."

Plan *now* to attend! All requests for hotel reservations, registration, etc. should be made to: Third World Congress of Psychiatry, Allan Memorial Institute, 1025 Pine Avenue West, Montreal 2, Canada.

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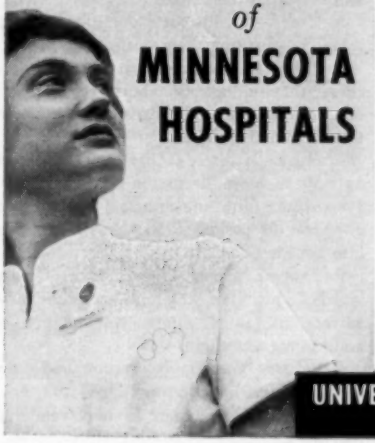

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THE MACMILLAN AWARDS, 1961

Once again we are indebted to the Macmillan Company of Canada for stimulating interest in the preparation by student nurses of studies in comprehensive nursing care. Some two dozen entries were received in this competition during 1960. With the cooperation of five highly qualified judges, selected from schools of nursing across Canada, we are happy to announce that a cheque for $25 has been sent to each of these students by the Macmillan Company of Canada. Sincere congratulations to:

First prize — Miss BARBARA CROW, Brantford General Hospital, Brantford, Ontario.

Second prize — Miss MARIETTE BREAULT, Edmonton General Hospital, Edmonton, Alberta.

In addition to the cash awards, the Macmillan Company of Canada has presented valuable book prizes to three other student nurses whose studies received Honorable Mention:

1. Miss AGNES DRISCOLL, St. Paul's Hospital, Vancouver, British Columbia.

2. Miss JUDITH ALLEN, University of Alberta Hospital, Edmonton, Alberta.

3. Miss MICHELINE BOIVIN, Jeffery Hale's Hospital, Quebec City, Quebec.

All of these comprehensive nursing care studies will be published in an early issue of *The Canadian Nurse*.

Seeing a car rolling down the street without a driver, a man dashed from the pavement, clambered into the car, and slammed on the brakes.

A second man appeared from the back of the car, puffing and complaining. "What's the big idea?" he asked. "I'm pushing my car to a petrol station, and you're the third quick thinker I've met in the last two blocks!"

* * *

Mother's note to teacher: "Please send Michael to the clinic at half-past two with his eyes, because they close at three."

ARE YOU A GOOD DISCUSSION LEADER?

TRUE OR FALSE.

1. You may do nothing between your introduction and summary except ask questions, and still do a good job of leading a discussion.

2. Differences of opinion generally hamstring a discussion.

3. When you "know the answer," you should save time by telling the group, rather than use the slower method of leading them to think their way to the answer.

4. You should state your view to encourage group members to state theirs.

5. When a member advances an unpopular opinion and is attacked by the group, you have a responsibility to defend him.

6. A side discussion can be stopped without chastising the participants.

7. Vote-taking is the only approved device for settling disagreements.

8. Even the long-winded member should be given full opportunity to say his piece.

9. "Atmosphere" changes in a discussion can be detected before they erupt.

10. The best number of members in a group is twenty-five.

11. An articulate expert is a constant help to a discussion leader.

12. You are a dead duck if the discussion gets out of control.

Give yourself 10 points for each right answer. A score of 100 or over is outstanding, 70 to 90 is good, 40 to 60 practise up. The "right" answers:

1. *True.* Socrates did it all the time, and look what a reputation for wisdom he gained!

2. *False.* They're an important asset. If everyone agrees, no one will go out wiser than when he came in.

3. *False.* The answer they think out requires real meaning and acceptability.

4. *False.* There will always be a number of insecure individuals who will refrain from bucking the leader.

5. *True.* Actually he's doing the group a favor — making them think.

6. *True.* For example, if you can assume they're talking about the subject under discussion, state that everyone would like to hear their ideas.

7. *False.* If there's that much lack of agreement, more discussion is needed.

8. *False.* The uncontrolled rambler is a prime discussion killer. You must help him get his point briefly.

9. *True.* Learning to recognize "feeling words," negative interactions and subsurface meanings equips you to predict and counteract them.

10. *False.* Experience recommends six to twelve as a limit in most cases.

11. *False.* The expert is best rendered inarticulate.

12. *False.* The fact that a conference occasionally does wrench loose from its mooring is proof of its spontaneity. And it's seldom a problem to restore peace and direction.

— Adapted from "The Efficient Executive," by AUREN URIS.

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ALBERTA

Supervisors, Head Nurses, General Duty Registered Nurses (all departments) Immediately, for completely modern 70-bed hospital presently under construction to be opened June 1961. Salary for General Duty Registered Nurses $300 to $330 per mo., salaries for supervisory & other key positions commensurate with experience. **Operating Room Supervisor (1) Operating Room Nurse** (Immediately) preferably with postgraduate course in operating room work & several years experience. **General Duty Nurses** (3) Immediately. For further information & personnel policies, please write: Miss J. Wickett, Matron, Municipal Hospital, Peace River, Alberta.

Science Instructor—Medical & Surgical Clinical Instructors for 45-student School of Nursing. **Registered Nurses for Medicine, Surgery & Operating Room.** Salaries for General Duty Nurse: $285-$315. Apply to: Director of Nursing, St. Joseph's General Hospital, Vegreville, Alberta.

Registered Nurses for 50-bed hospital, on main line between Calgary & Edmonton. Salary scale $285 to $325 commensurate with experience, less $40 for full maintenance. 3-wk. vacation, plus 10 statutory holidays after 1-yr. of service. Apply: Mrs. E. Harvie, Matron, Municipal Hospital, Lacombe, Alberta.

Registered Nurse preferably with Public Health training or experience needed for rural Health Unit in Alberta. Salary range according to qualifications & experience, an upward revision is shortly expected. Transportation is provided on & off duty within the Health Unit area to a limited extent. Provision is made for sick leave & holidays, pension plan available. For further particulars apply to: Minburn-Vermilion Health Unit, VERMILION, Alberta.

Registered Nurses (2) Certified Aides (2) for new 25-bed hospital, 185-mi. from Edmonton & Calgary. Medical care plan, expenses shared by Hospital Board. Salary $290 per mo. nurses, $190 Certified Aides, less $30 for room & board. Apply to: Matron, Miss E. M. Hoyt, R.N., Municipal Hospital, Coronation, Alberta.

Registered General Duty Nurses (2) for 20-bed modern hospital, 40-hr. wk., personnel policies upon request. Apply: Matron, Municipal Hospital, Myrnam, Alberta.

General Duty Registered Nurses for commencing duty May, June & July at $325 per mo., plus by-yearly increments. Paid holidays & sick leave, room & board $30 per mo., group medical & hospitalization plans. Apply: P.O. Box 339, Spirit River, Alberta.

General Duty Nurses Salary $285-$315 per mo. plus other benefits, 40-hr. wk. Train fare from any point in Canada will be refunded if employed for 1-year. For full particulars apply to: Municipal Hospital, Two Hills, Alberta, PHONE 335.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton. $275 gross salary for Alberta registered, $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

General Duty Graduate Nurses for busy 35-bed hospital 80-mi. East of Edmonton on C.N.R. main line & paved highway. Salary $290 with 8-semi-annual $5.00 increases. Excellent personnel policies, maintenance & laundry of uniforms available in hospital for $35. Alberta registration required. Apply: Matron-Supt., Municipal Hospital, Viking, Alberta.

BRITISH COLUMBIA

Director of Nursing for 110-bed hospital in Northwestern B.C. Salary open. Excellent personnel policies. Apply stating qualifications & experience to: Administrator, General Hospital, Prince Rupert, British Columbia.

Supervisor (Evening & Night Service) for 110-bed hospital in Northwestern B.C. Salary $357 - $428. Residence available. Apply stating qualifications & experience to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.O. Box 230, Golden, British Columbia.

Nursing Service Supervisor for General Hospital with school of nursing in interior of B.C. 204-beds, with plans for immediate expansion of hospital and school. To work under the direction of the Associate Director of Nursing. Salary range $342-$413 per mo., with recognition for experience and/or postgraduate preparation. Superannuation & medical health plans in effect. Registration in B.C. required. Applications should be addressed to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Operating Room Supervisor for 110-bed hospital, 3 surgeons, in Northwestern B.C. Salary $332 - $398, P.G. $10 extra. On-call pay with overtime. Apply stating qualifications & experience to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Matron for R. W. Large Memorial Hospital of the United Church of Canada at Bella Bella, B.C. 300-mi. north of Vancouver on the B.C. Coast. Salary $335-$360 per mo. Also **General Duty Nurse** required. Salary $285, 2 annual increments of $5.00 per mo., transportation to Bella Bella refunded after 1-yr. Apply to: The Administrator, R. W. Large Memorial Hospital, Bella Bella, British Columbia.

Registered Nurses (2) for 30-bed hospital. B.C. Registered Nurses salary agreement in effect. Past service recognized for salary purposes. Board & room $40, 1½-days sick leave per mo., 40-hr. wk., 11 statutory holidays & 28-days vacatioin after 1-year service. Comfortable nurses' residence next door to hospital. Rotating shifts. Please apply to: The Matron, Community Hospital, Grand Forks, British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write. The Administrator Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $297 to $359. Pre-planned shift rotation, B.C. registration essential. 4-wk vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses Salary $297 per mo., increase of $12 after 1-yr. service. Charge for room, board & laundry $40; all statutory holidays paid, 28-days vacation after year's service. Graduate complement six (6). Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—non-registered $297, B.C. registered $312-$374. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $307, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for 25-bed hospital, 35-mi. Vancouver, on coast. Close to Garibaldi Park Ski-ing lodge. 1-hr. to city, bus & train service. Salary BCRN $285 - $359 (4th. yr.) non-BCRN $270 - $282 (1st. yr.) Excellent personnel policies. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $297, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. Very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $297-$359. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $285 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $297 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with 4 annual increments of $14, 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Graduate Nurses (4) immediately for 40-bed hospital. Salary $300 per mo. for B.C. Registered Nurses & $15 less per mo. for non-registered nurses. 3 yearly increments, 40-hr. wk., 1½-days sick leave with pay per mo., 28-days vacation with pay after 1-year of employment & 10 legal days per year. Fare from anywhere in Canada advanced & need not be repaid if you stay 6 months. Superannuation benefits, uniforms are laundered gratis by the hospital. There is a new modern residence which is available for $45 to $50 per month. Interesting social advantages as an excellent Choral Group, excellent educational opportunities and good sporting, Skating, Bowling, Fishing, Boating, Curling, Hunting, etc. Kindly apply giving references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

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Matron for fully modern 15-bed hospital situated 70-mi. north of Winnipeg. Starting salary $350 per mo., living-in accommodation. For further particulars apply to: Mrs. E. L. Johnson, President. Arborg Memorial Hospital Board, Arborg, Manitoba.

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(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 705 Commercial Building, 169 Pioneer Avenue, Winnipeg 1, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

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Operating Room Supervisor for 125-bed hospital. Apply to: Director of Nursing, Grace Hospital, 650 Church Street, Toronto 5, Ontario.

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Registered Nurses $300 per mo. min. to max. $340, 3-weeks vacation with pay, sick leave after 6-mo. service. Non Registered — $15 less, Cert. N.A. $210 min. to max. $240, 2-wks. vacation with pay, Non Certified Cert. N.A. $200 to max. $230. Increases for both groups $10 per mo. after 1-yr. on staff. 9-statutory holidays. All staff:— 5-day 40-hr. wk. Apply: Superintendent, Englehart & District Hospital, Inc., Englehart, Ontario.

Registered Nurses ($275-$305) for 300-bed Tuberculosis Hospital, situated at the head of the lakes. Good personnel policies. For details apply to: Director of Nursing, Fort William Sanatorium, Fort William, Ontario.

Registered Nurse with C.S.L.T. or equivalent experience, required for Blood Bank work. Good personnel policies, salary & benefits in effect. For particulars, apply to: Director of Personnel, General Hospital, Kingston, Ontario.

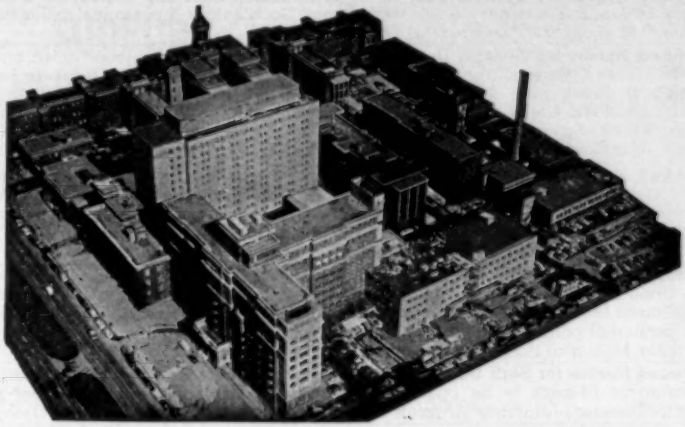
Registered Nurses for 60-bed hospital. Salary $280 per mo. gross. Good personnel policies. For further particulars apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

Registered Nurses, Certified Nursing Assistants for modern 75-bed hospital. Starting salary: R.N.'s $300 per mo. with merit increases after 6-mo. service, C.N.A.'s $216 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in this 42-bed hospital. Starting salary $300 & $210 respectively. Accommodation in new residence. Deduction for room & board $40. Pension plan available & other benefits. For full information apply to: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses for General Duty (2) urgently needed for 48-bed hospital. Highest salary paid. Telephone 378 or reply to: The Administrator of St. Joseph's General Hospital, Little Current, Ontario.



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Registered Nurses for General Duty in modern 40-bed hospital in resort town on beautiful Lake Huron. Starting salary $285, 40-hr. wk., 10 working days sick leave in 1-yr., 50% unused sick leave paid in cash at end of year. 50% single OHSC premium paid, 8 statutory holidays, 4-wks. vacation after 1 year, board & room $30, modern living quarters. Transportation allowance after 1-year service. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital, in iron mining town, 150-mi. north of Sault Ste. Marie, Ontario. Starting salary $281 min. to $316 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $285 per mo.** with annual merit increments, **plus annual bonus plan.** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

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Registered Staff Nurses for Operating Room Department: A new, well equipped unit; rotating hours of duty; attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $285, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $285 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; $285 gross. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for 350-bed General Hospital located in downtown Toronto — Rotating hours of duty, attractive personnel policies, in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

Public Health Nurses (Qualified) Generalized program includes some bedside nursing. Salary $3,500 - $4,500; annual increment $200, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurse (qualified) for Red Lake, Ontario. Salary $3,790 with 5 annual increments of $175, car provided, pension plan, provision for sick leave & holidays. Red Lake is in the center of a gold mining & tourist area. Apply to: Dr. E. R. Langford, M.O.H., District of Kenora Health Unit. Box 174, Kenora, Ontario.

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Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurses for generalized public health nursing service, in suburban & rural areas. Minimum salary $3,600 per year, car allowance, pension plan & other benefits. Apply to: Dr. D. G. H. MacDonald, M.O.H. 44 Nelson Street West, Brampton, Ontario.

Public Health Nurses (qualified) for generalized program. Minimum salary $3,750 with annual increments & allowance made for experienced nurses. Apply to: Supervisor of Nursing, Fort William & District Health Unit, 900 Arthur Street, Fort William, Ontario.

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Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply: Matron, King Edward VII Memorial Hospital, Bermuda.

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Clinical Instructor in Rehabilitation Nursing and Rehabilitation Nurse for expanding program in a New England rehabilitation facility. Full details upon request. Write Box N, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Operating Room Supervisor for modern, accredited 60-bed hospital. Living accommodation available in new motel-style nurses' residence. Apply stating qualifications & salary expected to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurses & Trained Nursing Assistants for hospital specializing in Chest Diseases (in Montreal area). Excellent personnel policies, working conditions & accommodation in the Nurses' Home. Reply to: Box 1000, Ste. Agathe des Monts, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $275 per mo. 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

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SASKATCHEWAN

Matron, Registered Nurses (2) Immediately for Union Hospital. Salaries as per SRNA schedule, plus benefits, 40-hr. wk., daily bus service. Apply to: Fred Howlett, Secretary, Box 140, Union Hospital, Mossbank, Saskatchewan.

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living ahsommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accomulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital, Leader, Saskatchewan.

U.S.A.

Supervisors & Nurses for 80-bed County Hospital. Starting salary $337 - $395 plus normal increases, 3-wk. vacation. Situated in picturesque mountain foothills. No smog or rain, leisurely living-in home-like congeniality. Near Los Angeles, San Diego, Las Vegas & 8-mi from historic Mexico. Send for descriptive letter. Mr. L. J. Lonni, Imperial County Hospital, Box 1771, El Centro, California.

Operating Room Supervisor for 238-bed JCAH approved hospital. Intern, Resident & Nursing Education programs. Candidates with BS degree preferred. Apply to: Mrs. Virginia Krahl, Director of Nursing Service, Cottage Hospital, 320 West Pueblo Street, Santa Barbara, California.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Residence, Cook County School of Nursing

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Affidavits of employment will be furnished to qualified applicants.

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Charge Nurses evening & night in our medical & surgical departments. How about California for late spring & early summer? The days are beautiful & warm — the evenings are cool. Positions are now available at Los Angeles County General Hospital. Salaries begin at $460 per mo. & advance to $536 per mo. A California license is not difficult for Canadian registered nurses to obtain. Why not make plans to come to sunny California today? Contact: Evelyn Nine Spees, R.N., Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California. P.O. Box 1311.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $350 with range to $390 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

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Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40 hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses — Openings for General Staff Duty in all services including orthopedics, pediatrics, obstetrics, intensive therapy, rehabilitation, surgery. Challenging opportunities for personal & professional advancement. Apply: Personnel Director, Mount Zion Hospital & Medical Center, 1600 Divisadero Street, San Francisco 15, California.

HEAD NURSE, NURSERY: for new 254-bed JCAH approved District Hospital, San Francisco Bay Area. Entrance salary $375 per mo. with range to $415 plus $10 per mo. Special Area differential. Training & demonstrated performance in nursing unit management in this clinical specialty. Prefer at least (1) year's experience in Nursery as Head Nurse with proven executive ability. Excellent modern housing, schools & colleges easily accessible. Free employee hospitalization & surgical coverage. Uniforms laundered free, other attractive fringe benefits. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $345 - $415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.

Registered General Duty Nurses (3) for small General Hospital. Starting salary $350 to $400 after 1st year. Furnished apt. available. Apply by writing: Box 336, **Dos Palos,** California, or Phone Collect Express 2-3450 after 6 p.m.

General Duty Nurses JCAH accredited 100-bed hospital, 3½-hrs. auto distance from L.A. or San Francisco. Your choice of climate. Salary range from $351-$415 for Staff Duty & $392 - $464 for Supervision. Nurses' residence quarters $10 per mo., 40-hr. wk., 15-days vacation, 11 holidays. Social Security & Retirement Plan. 3 Canadian nurses on staff appreciated — others in nearby hospitals. Write: Director of Nursing, County Hospital, Tulare, California.

Staff Nurses General Hospital within 20 minutes of New York City. Openings on all services & shifts. Salary & benefits equal to or exceeds other hospitals in North Jersey area. Contact: Personnel Department, St. Elizabeth Hospital, 204 So. Broad Street, Elizabeth, **New Jersey.** — PHONE EL 5-3100.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $350 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

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Salary commensurate with experience and qualifications.

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Registered Nurses — Excellent opportunities for Staff Nurses in large hospital. Salary range for permanent evenings & nights $420-$450, rotating range $390 - $420. Private room accommodation at reasonable rates. Centrally located. Convenient transportation. Write to: Director of Nursing Service, Dept. A.J.N., Mount Sinai Medical Center, 2750 West 15th Place, Chicago 8, Illinois.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation. 718 Glenview Ave., Highland Park, Ill.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi from Boston. Living quarters available. Minimum starting pay $70 R.N.'s., L.P.N.'s $58 per wk. Experience considered, diferentials for reliefs, nights. Contact: Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

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Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Supervisors — Medical-Surgical, Pediatrics, Obstetrics & Psychiatric. Base salary $400 to $439, depending upon preparation & experience. Liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs. Housing available on campus or in vicinity of hospitals. Apply: Director Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

General Duty & Operating Room Nurses for 210-bed General Hospital. Start $335 days, $360 evenings, $355 nights, plus $10 for O.R., university city, 40-hr. wk., 7 holidays, extended vacations, sick leave benefits, free Blue Cross hospital-medical insurance & $2,500 life insurance, retirement program plus Social Security, extensive Intern-Resident Educational Program, living quarters available. Write, Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

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General Duty Nurse for 16-bed hospital, starting salary $285 per mo., 40-hr. wk., board & room $35, uniforms laundered free. Muncipal Hospital, Elnora, Alberta.

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Registered Nurse for Operating Room in small Public General Hospital. Good salary, personnel policies & pension plan, living-in accommodation if desired. Apply to: Director of Nursing, Sensenbrenner Hospital, Kapuskasing, Ontario.

Public Health Nurses (qualified) for an expanding urban-rural Health Unit. Personnel policies on request. Apply to: Director of Nursing, Simcoe County Health Unit, Court House, Barrie, Ontario.

Public Health Nurse (Qualified) for a generalized program in Etobicoke Township. Minimum salary $3,925. Car allowance $670 per annum. 4-wk. vacation after 1-year. The usual employee benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Road, Etobicoke, Ontario.

SASKATCHEWAN

General Duty Registered Nurses for 80-bed hospital, salary $285 - $360 per mo., with increments every 6-mo., 40-hr. wk. 8-statutory holidays, cumulative sick leave, 3-wk. annual vacation, credit for past experience & postgraduate preparation. Apply: Sister Superior, St. Joseph's General Hospital, Estevan, Saskatchewan.

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Graduate Nurses: Permanent & holiday relief nurses for active 50-bed hospital 35-mi. from Vancouver. RNA of B.C. recommendations implemented. Apply to: Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

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Instructors in Obstetrics, Pediatrics, Operating Room, Medical & Surgical Nursing, Psychiatry for all modern 700-bed hospital. Salary $360 - $400. Degree preferred but will accept certificate in teaching. Liberal personnel policies. Apply to: Director of Nursing, St. Boniface General Hospital School of Nursing, St. Boniface, Manitoba.

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Administrative Supervisor evening and night rotation of duty.
Administrative Supervisor for Operating Room
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Instructor in Medical Nursing
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THE DIRECTOR OF NURSING

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Apply to: The Executive Secretary

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Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $387 - $507 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

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GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

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Director — Nursing Service, University Hospitals of Cleveland, Ohio.

NOTRE DAME HOSPITAL OF MONTREAL

NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 10 days; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year, Pension plan.
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LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

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FOR ALL DEPARTMENTS

Gross salary $285-$315 monthly ($131.20 - $145 bi-weekly) $265 monthly ($122 bi-weekly) until registered. Rotating periods of duty — 40 hour week, 8 statutory holidays, annual vacation 21 days. Annual sick time 12 days, cumulative to 18 days. Hospitals of Ontario, Pension plan, Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $280 to $320 gross per month. Differential for evening and night duty. Temporary residence accommodation if desired.

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KENORA, ONTARIO

requires

2 Public Health Nurses

Salary: - Minimum — $3,500 Maximum — $4,375

Car provided, pension plan, attractive personnel policies. This progressive Health Unit is situated in the heart of the Lake of the Woods tourist area.

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REQUIRES

INSTRUCTOR IN PEDIATRIC NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include clinical and classroom instruction.

Requirements: University preparation in Nursing Education
Salary differential for degree.

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(A) OPERATING ROOM NURSE
with postgraduate training

(B) OBSTETRICAL SUPERVISOR
with postgraduate training

Good personnel policies, attractive community.

Apply to:

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QUALIFIED INSTRUCTOR
required by August for 110-bed hospital, 60 students
also
MEDICAL-SURGICAL CLINICAL INSTRUCTOR
Good personnel policies, attractive community.

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DIRECTOR OF NURSING, ORILLIA SOLDIERS' MEMORIAL HOSPITAL, ORILLIA, ONTARIO.

JEFFERY HALE'S HOSPITAL
SCHOOL OF NURSING

requires

SCIENCE INSTRUCTOR

CLINICAL INSTRUCTOR

by August 1st. 1961. One Class (approximately 20) yearly in September.

Qualified applicants are asked, to write to:

MISS K. MARSHALL,
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JEFFERY HALE'S HOSPITAL,
QUEBEC 6, QUEBEC.

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL & } DEPARTMENTS
OBSTETRICAL

Apply

EDITH G. YOUNG, REG.N.,
ADMINISTRATOR OF NURSING

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.
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WANTED

Salary — $265 - $315 per month 40-hour week, no split shifts.

Vacation — 3 weeks after one year; statutory holidays — eight (8); sick leave — cumulative from date of employment.

Transportation — advanced on repayable basis. For 75-bed fully accredited hospital built in 1956, located in south-western Ontario.

Apply to: Director of Nursing,
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Further your Nursing Experience

Opportunities open for
GRADUATE NURSES
in all areas

Liberal personnel policies
Hospital within walking distance of
Wayne State University

Every effort is made to provide the opportunity for each nurse to reach her potential

Must be eligible for registration in the State of Michigan

Write:
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Salary - $300 to $320 per month 40 hour week, no split shifts.

Vacation - 18 days plus 10 statutory holidays a year, 21 days sick leave cumulative from time of employment.

Transportation will be advanced if necessary.

Apply: Matron,
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INSTRUCTORS

with postgraduate preparation

required

in 160-bed General Hospital
School of Nursing for:

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Duties to commence August 1961

Apply in writing to:
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BRANDON, MANITOBA

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Invites application for

GENERAL DUTY NURSES

for Operating Room, Surgical, Medical & Obstetrical Units.

For further information write:
THE DIRECTOR OF NURSING,
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Supervisor for the Maternity Department. 4-wks. vacation entitlement, a pension plan and 40-hr. week in effect.

For details as to salary, and other benefits, apply to:

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REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

DIRECTOR OF NURSING,
ROSS MEMORIAL HOSPITAL,
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2175 Keele St., Toronto 15, Ont.

Considering a change or moving to Toronto? Write to Northwestern for information. New addition nearing completion, there will be employment opportunities for

Registered Nurses and Certified Nursing Assistants.

THE CHILDREN'S HOSPITAL OF WINNIPEG

REQUIRES

PEDIATRIC CLINICAL INSTRUCTORS

- Recent University postgraduate course and teaching experience preferred
- Salary based on qualifications and experience
- Up-to-date personnel policies
- For further information, apply to:

THE DIRECTOR OF NURSING
THE CHILDREN'S HOSPITAL
WINNIPEG 3, MANITOBA

PUBLIC HEALTH NURSES

FOR

Generalized program

IN

Seaway Development Area

Usual benefits, Pension Plan, allowance for experience

Apply to:

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HEALTH UNIT
26 PITT STREET
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SCHOOL OF NURSING

Invites application for the position of

SCIENCE INSTRUCTOR

Good personnel policies

New school of nursing opening September 1961

Write: Director of Nursing

WOODSTOCK GENERAL HOSPITAL
WOODSTOCK, ONTARIO

Applications are invited for

GENERAL STAFF NURSES

for Operating Room, Obstetrical, Medical and Surgical departments.

Good personnel policies

Apply:

DIRECTOR OF NURSING,
WOODSTOCK GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH

B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY $346-$405 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, write to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION NO. 60:484.

EDUCATIONAL OPPORTUNITIES

UNIVERSITY OF BRITISH COLUMBIA

School of Nursing

DEGREE COURSE IN BASIC NURSING

DEGREE COURSE FOR GRADUATE NURSES

Both of these courses lead to the B.S.N. degree. Graduates are prepared for public health as well as hospital nursing positions.

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UNIVERSITY OF SASKATCHEWAN

SCHOOL OF NURSING
in cooperation with
UNIVERSITY HOSPITAL

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Teaching and Supervision. To prepare for positions in teaching and supervision in Schools of Nursing.

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Credits earned may be applied toward the degree of Bachelor of Science in Nursing.

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Bachelor of Science in Nursing. Students with senior matriculation may enroll in a combined academic and professional program.

Diploma in Nursing. The School also conducts a three-year hospital program.

For further information apply to:
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SASKATOON, SASKATCHEWAN.

MONTREAL NEUROLOGICAL INSTITUTE McGILL UNIVERSITY

GRADUATE COURSE
in
NEUROLOGICAL AND NEUROSURGICAL NURSING AND OPERATING ROOM TECHNIQUE

Classes: Apr. 1 & Oct. 1

One half staff salary is paid during course. Students may live in or out.

For information apply:

MISS E. C. FLANAGAN, B.A., R.N.
Director of Nursing,
3801 University St.
Montreal, Que.

THE WINNIPEG GENERAL HOSPITAL

Offers to qualified **Registered Graduate Nurses** the following opportunity for advanced preparation:

A six month *Clinical Course* in *Operating Room Principles and Advanced Practice.*

Courses commences in JANUARY and SEPTEMBER of each year. Maintenance is provided. A reasonable stipend is given after the first month. Enrolment is limited to a maximum of six students.

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DIRECTOR OF NURSING
GENERAL HOSPITAL
WINNIPEG, MANITOBA

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING
MONTREAL, QUEBEC

Postgraduate Courses

1. (a) Six month clinical course in Obstetrical Nursing.

   Classes—September and February.

   (b) Two month clinical course in Gynecological Nursing.

   Classes following the six month course in Obstetrical Nursing.

   (c) Eight week course in Care of the Premature Infant.

---

2. Six month course in Operating Room Technique and Management.

   Classes—September and March.

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3. Six month course in Theory and Practice in Psychiatric Nursing.

   Classes—September and March.

Complete maintenance or living-out allowance is provided for the full course.

Salary—a generous allowance for the last half of the course.

Graduate nurses must be registered and in good standing in their own Provinces.

For information and details of the courses, apply to:—

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Director of Nursing,
Royal Victoria Hospital
Montreal, P.Q.

THE NATIONAL HOSPITAL

Queen Square, London, W.C.1., England

(MEDICAL NEUROLOGY AND BRAIN SURGERY)

ADVANCED NURSING EDUCATION

One year courses are open to graduates of accredited Schools of Nursing having good educational background.
Three months academical teaching in the School of Nursing under guidance of Sister Tutor assisted by large teaching Staff of Senior Neurologists and Neuro-Surgeons.
Eight months Clinical experience, one month vacation.
Certificate and badge of the hospital awarded to successful students. Full graduate salary paid throughout the year. This work has a special appeal to nurses interested in research and the humanitarian aspect of Nursing.

Apply to:

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KENTVILLE N.S.

Offers to Graduate Nurses a Three-Month Course in *Tuberculosis Nursing*, including Immunology, Prevention, Medical & Surgical Treatment.

1. Full series of lectures by Medical and Surgical staff.
2. Demonstrations and Clinics.
3. Experience in Thoracic Operating Room and Postoperative Unit.
4. Full maintenance, salary & all staff privileges.

For information apply to:

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School of Nursing

Degree Course in Basic Professional Nursing
Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing **and the Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.

Degree Course for Graduate Nurses
Graduate nurses who wish to obtain the degree of Bachelor of Nursing are required to complete the three years of university work.

Diploma Courses for Graduate Nurses
(a) Public Health Nursing
(b) Teaching in Schools of Nursing
(c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
DALHOUSIE UNIVERSITY, HALIFAX, N.S.

SCHOOL OF HYGIENE

UNIVERSITY OF MONTREAL

Course in public health nursing in French

DIPLOMA IN PUBLIC HEALTH NURSING (D.P.H.N.)

One year course offered to nurses who hold a diploma from a School of Nursing recognized by the University or who is licensed to practice by a professional association.

Because nurses are called upon to cooperate with other public health workers as members of the same team, the program is planned so that all take some courses together; only particular nursing courses are attended solely by nurses.

For information address to:

Directrice des Infirmières Hygiénistes, Ecole d'hygiène
Université de Montréal, C.P. 6128, Montréal.

AN EXTENSION COURSE IN NURSING UNIT ADMINISTRATION

Those nurses who are interested in enrolling for the Extension Course in Nursing Unit Administration should submit their applications not later than April 30th, 1961. Applications will be accepted from nurses who are engaged in positions of assistant head nurses, head nurses or supervisors and who are unable to attend a university school of nursing. Directors of nurses in small hospitals may also enroll.

The course will start with a workshop in September to be followed by a seven month period of home study. A final workshop will be held in May 1962.

This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association.

Information and application forms may be obtained by writing to:

DIRECTOR, EXTENSION COURSE IN NURSING UNIT ADMINISTRATION, 25 IMPERIAL STREET, TORONTO 7, ONTARIO.

ST. JUSTINE'S HOSPITAL

offers

Postgraduate courses for

REGISTERED NURSES

in

- Pediatrics in cooperation with the Marguerite d'Youville Institute, and leading to a university certificate as well as a postgraduate course in the
- Care of the Premature Infant in cooperation with the Minister of Health of the Province of Quebec.
- As well as two other eight-month postgraduate courses in:
- Pediatrics and
- Obstetrics.

Admission in October.

Ability to speak French essential.

For further information write to:

LA DIRECTRICE DE L'ECOLE DES INFIRMIERES, HOPITAL SAINTE-JUSTINE 3180 AVENUE ELLENDALE MONTREAL 26, QUE.

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Notre Dame Hospital of Montreal

- GENERAL MEDICINE
- GENERAL SURGERY
- OPERATING ROOM
- OBSTETRICS

Classes: March and September

Duration: 6 months

Substantial remuneration

Meals and laundry provided.

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For further information write to:

LA DIRECTRICE DU NURSING HOPITAL NOTRE-DAME 1560 EST, SHERBROOKE, MONTREAL, QUEBEC.

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Registered Nurses a 16-wk. supplementary program in pediatric nursing. Admission dates, January 3, May 2, August 29, 1961; January 3, May 8, 1962.

For complete information write to:

DIRECTOR OF NURSING
2125-13th STREET, N.W., WASHINGTON 9, D.C.

Applications will be received

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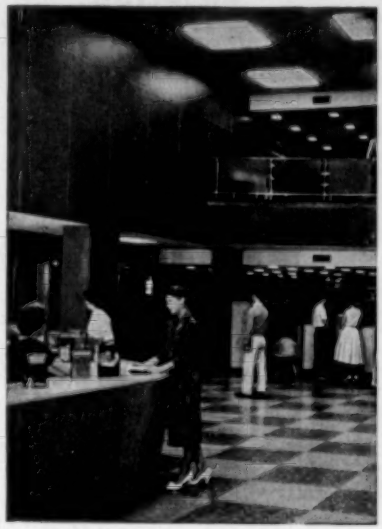
Louise D. Acton Scholarship of $500

given by the Kingston General Hospital Nurses' Alumnae, for the purpose of postgraduate study.

Please apply by May 15, 1961 to:

Mrs. B. ARNIEL,
Secretary, Kingston General Hospital
NURSES' ALUMNAE
190 BAGOT STREET, KINGSTON, ONTARIO

CAREER ADVANCEMENT FOR NURSES



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1. Bachelor of Science in Nursing — two years
2. Diploma — one year
   Professional courses include special emphasis on liberal education.

Residence Facilities — Gymnasium — Pool — Counselling Services

APPLY TO:

NURSING DEPARTMENT,
ESSEX COLLEGE,
Assumption University
of Windsor,
Windsor, Ontario.

UNIVERSITY OF NEW BRUNSWICK SUMMER SCHOOL

JULY 3 — AUGUST 12, 1961

FOR GRADUATE NURSES:

1. Ward Administration

Lectures and Seminars 3 hours per day
Lecturer — Miss Dorothy Hibbert, R.N., M.A.
Assistant Professor, University of Saskatchewan

2. Medical and Surgical Nursing

Lectures 2 hours a day for 5 weeks
1 week concentrated clinical practice
Lecturer — Miss Irene Leckie, R.N., M.S.
Associate Professor, University of New Brunswick

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Additional Courses may be selected from the Summer School Offerings

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Registration requested by June 15, 1961

For further information write:

DIRECTOR OF SUMMER SESSION
UNIVERSITY OF NEW BRUNSWICK, FREDERICTON, N.B.

COURSES
FOR
GRADUATE NURSES
in various clinical fields.

Terms begin April 3, 1961, June 26, 1961, September 18, 1961, December 11, 1961 and March 5, 1962. Rooms, meals, laundering of uniforms, and honorarium provided.

Apply to:

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OF NURSING,
DEPT. C., 1900 WEST POLK ST.,
CHICAGO 12, ILLINOIS.

THE JOHNS HOPKINS HOSPITAL
SCHOOL of NURSING

Offers to qualified Registered Nurses a 16-week supplementary course in

OPERATIVE ASEPTIC TECHNIC

with instruction and practice in the general surgical, neurosurgical, plastic orthopedic, gynecologic, ophthalmologic, urologic and ear, nose and throat operating room services. Maintenance and stipend are provided.

For information write to:

DIRECTOR, SCHOOL OF NURSING
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WILLS EYE HOSPITAL
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The largest eye hospital in the United States offers a six-month course in *Nursing Care of the Eye* to *Graduates of Accredited Nursing Schools*, Operating Room Training is scheduled in the course.

- Full maintenance and a stipend of $237 per month for the first three months, $247 per month for the last three months, plus maintenance.
- REGISTRATION FEE IS $20
- Course starts **September 16th & March 16th.** Ophthalmic Nurses in great demand for hospital eye departments, operating rooms & ophthalmologists' offices.

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Director of Nurses,
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THE CHARLES T. MILLER HOSPITAL

offers qualified Graduate Nurses a 16 weeks' course in

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The course includes instruction and supervised experience in all surgical specialties as well as teaching and management techniques.

Room, board, laundry and a stipend of $125 per month are provided.

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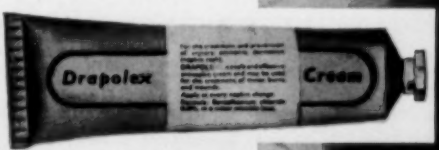

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